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ORIGINAL LECTURES.

AMERICAN NOTES.[1]

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A TRIP across the Atlantic has now been made so light an undertaking that it certainly cannot be the subject of a paper such as might have been written some twenty or five and twenty years ago, yet it seems that so few of our medical brethren on this side of the world take advantage of the facilities for the journey that it is quite possible I may be able to say something of interest to you about it. This is the more likely to be the case, as I undoubtedly was favored with most exceptional opportunities of meeting my professional brethren during my brief stay in America. I saw them under all kinds of circumstances—in their hospitals, in their class-rooms, in their private practice, and in their domestic circles—to the fullest advantage. They come over here in numbers so large that I had gained an impression that they must be a much richer body than we are, for it certainly is a very unusual thing in this country to find a practitioner, however eminent, taking a voluntary holiday for three or four months, or even as long as a year, yet we find this is quite a common luxury amongst our trans-atlantic brethren. I felt a considerable amount of curiosity upon this subject, and therefore I made inquiries, the result of which quite convinced me that this practice has not its origin in greater wealth or more freedom from competition; on the contrary, I found that it springs from an earnest and laudable desire to extend their knowledge and increase their powers of usefulness, that they may thereby stand higher in the estimation of their clients.

They have, in America, institutions which are quite unknown in Europe, called post-graduate colleges, and in this they seem to me to recognize, to a much greater extent than we do, that after graduation a doctor's medical education is just about to commence. Thus, in New York there is a large institution called the "New York Polyclinic," a school of clinical medicine and surgery for practitioners. It is described as an institution "in which there are didactic lectures given, practitioners only being admitted, and the class being limited, so that each case may be minutely and leisurely examined and thoroughly understood." The list of teachers includes some of the most eminent men in the various departments of practice in New York. It is managed by the board of directors, which includes Fordyce Barker, Frank Hastings Hamilton, Thomas Addis Emmet, Alfred L. Loomis, and T. Gaillard Thomas. I am certain there is nothing of this kind in Great Britain, and I never saw anything on the Continent with which I could compare it.

[1] Read before the Birmingham Medical Society October 31, 1884.

American doctors regard a run over to Europe every few years as a kind of class-taking in a cosmopolitan post-graduate college; and, from what I have seen of surgical practice on our own continent, in this country, and in America, I have no hesitation whatever in recording my opinion that it would be vastly beneficial to both Continental and English surgery if return visits were made in large numbers. I do not say we are lacking either in surgical culture or in earnestness of purpose, but on the great Western Continent there is an enthusiasm, a vivid interest in life, a regular go-aheadness, of which it would be well if we had a stronger infusion. The general summary of my visit to the United States and to Canada may be briefly put in the statement that no Englishman can obtain a reasonably full grasp of how the world is moving, or of the numerous phases of life, medical and surgical as well as others, until he has seen life across the Atlantic.

I purpose, in this paper, only to tell you in a running sketch what I saw from day to day, as I passed from one city to another, and to give you my general impressions of what I saw. This will answer the request made to me far better than any elaborate disquisition upon specific subjects, as such a paper would require a much longer stay, and a deeper critical investigation, than was possible in the time at my disposal.

Let me say here, in passing, just a word upon the subject which was raised by a paragraph in a recent number of one of our leading medical journals. I mean the position and competency of the surgeons on the Atlantic line steamers. Of course, I saw only two of these gentlemen—one on my outward journey, and the other on my return—but, if they may be taken as samples of their class, I do not hesitate to say that the insinuation contained in the paragraph in question amounted to a grave misstatement. It so happened that on both of my journeys there were cases on board of very considerable gravity, which, as a matter of course, formed a subject of professional conversation between myself and the surgeons of the ships, and I express my opinion, without the slightest hesitation, that for culture and professional competency these two gentlemen were quite equal to anything which is usually met with in our life on land. As regards their social position, they are treated thoroughly well by the companies in whose service they are, and by the passengers with whom they are in daily contact, and I would point out that no kind of life can be regarded as more harassing than that in which a man may be shut up for ten days with a case of the gravest possible kind, and absolutely removed from any advice or assistance from a professional brother, save by the accident of some of the passengers belonging to the same craft.

I never fully understood what a terrible thing this isolation may be until I had a little experience of it on my own account on board one of the steamers on the St. Lawrence. I left Montreal about eight o'clock in the evening for the night journey to Quebec. About

one hour after I was comfortably in bed and asleep, I was roused by one of the officers of the ship, to whom my presence on board had been communicated, to come to the assistance of a young lady, who was said to be bleeding to death. I hurriedly dressed, and when I reached the ladies' cabin I found that the sufferer had accidentally broken a pane of glass with her elbow and had inflicted a severe wound on the fleshy part of the arm, from which she had lost a very large quantity of blood. This hemorrhage had, fortunately, been arrested by a rude kind of tourniquet, and round the couch were gathered a number of terrified priests and nuns, who were engaged in arranging a service for the dying. A steward held a smoking oil lamp, and the helpless captain stood by with an antiquated medicine chest. It became at once perfectly clear to me that the brachial artery had been injured, and so much blood had been effused amongst the tissues that the task of securing the bleeding points would be no easy one. The only instruments available were a bleeding-lancet, a pair of dissecting-forceps, and an old-fashioned aneurism-needle. Fortunately, amongst the drugs there was a small bottle of chloroform, and, after much difficulty in overcoming the terrors of those who surrounded me, I put the patient under chloroform and made an incision over the place where, after a lapse of some twenty years, I still had an idea the brachial artery might be found. Luckily for myself—still more luckily for the child—I stumbled upon the vessel and tied it, and I venture to say I never in my life was more devoutly thankful than to see that patient, three days afterwards, in a condition of convalescence. I have since been informed that her recovery is complete.

After I landed, the first city I visited was Boston, perhaps the most famous of the cities of the States in medical as in other matters. Amongst the members of its medical profession were many old friends, and during the few days I stayed there, I think I may say I was enabled to see everything. In the first place, I saw a monument erected not so much to an individual as to the accomplishment of a great discovery, the establishment of a great principle. In the large square of the city a graceful erection of stone, known as the "Ether Monument," commemorates the date upon which it was ascertained that a vast amount of human misery could be relieved with mathematical certainty, and the date from which the greatest triumphs of surgery must be reckoned. I need not tell you that to myself this monument had a special interest, for without anæsthesia the whole realm of work to which I am devoted could never have been built up. Thence I was taken to the Massachusetts General Hospital, where I saw the sponge upon which ether was given to the first patient upon whom an operation was performed while in a condition of profound artificial sleep, and the theatre in which the great triumph was achieved remains much the same as it was then. The hospital itself is a magnificent building of granite built very much on lines of hospitals of its time. It was completed in 1821, and on account of its immense solidity the original building seems to have been very little altered, though many additions have been made to it. One of these is of a very noteworthy character, in the form of a new out-patient department recently erected at the cost of a young gentleman now studying medicine within its walls. Originally built outside the city, like our own institution in Summer Lane, the hospital is now surrounded, though not closely, by buildings on all sides, and the rapid growth of the population here as elsewhere in America may be well indicated by the statement made to me by one of my surgical friends, Dr. Homans, who is attached to the hospital. He is by no means an elderly man, yet he could tell me that whilst a youth he had often shot wild duck in the hospital grounds.

It was, of course, towards the practice of abdominal surgery that I directed most of my inquiries, and I found that in Boston its progress is rapidly becoming satisfactory. Dr. Homans visited me here about two years ago and he has confessed himself as having been largely converted to my views and methods of practice. He showed me a series of fifteen cases, some of them of an extremely serious character, all in progress of recovery, and this in spite of the enthusiastic Listerism to which he subjects all his patients. But his methods have become very much simplified by his experience in England, and he was good enough to admit his indebtedness to what he saw here. He does not perform any of these operations in the public hospital, most of them are accomplished in a small and very well-regulated institution, at the head of which is an English lady belonging to a Sisterhood. During the last twelve months he has performed twenty-seven ovariotomies without a death.

Perhaps the most interesting building in Boston for me was the new medical school, which forms a department of Harvard University. This building was opened on the centenary of the establishment of the school with an address by Dr. Oliver Wendell Holmes, the Emeritus Professor of Anatomy, and in the theatre devoted to the teaching of that science I saw a most striking portrait of the Autocrat of the Breakfast-Table, appropriately placed on the scene of his labors. He has secured for himself a niche high on the wall of fame as a poet and as a writer of fiction, but he has a still higher place in the memories and the affections of the thousands he has taught in this school.

Dr. Holmes delivered an address of marvellous eloquence at the opening of the new building of the medical school on the one hundredth anniversary of its existence, and some of the passages in it are worth quoting, alike for the brilliancy of their language and the quaintness of their thought. He tells us, for instance, that

"We are in the habit of counting a generation as complete in thirty years, but two lives cover the whole century by an easy act of memory. I, who am now addressing you, distinctly remember the Boston practitioner who walked among the dead after the battle of Bunker's Hill, and pointed out the body of Joseph Warren amongst the heaps of slain."

He tells his hearers that then there were

"Three teachers only, where we now have forty or nearly that number! But when the great University of Göttingen was established, the illustrious Haller filled the one chair of botany, anatomy, surgery, and medicine. I called it a chair; it was rather a settee of professorships."

The buildings themselves are certainly the most perfect in their arrangement and the most complete in their appointments of any buildings I have ever seen erected

for a similar purpose, with, perhaps, the exception of the new buildings of the University of Edinburgh.

And finally of this beautiful building the Autocrat of the Breakfast-Table thus speaks at the close of his address:

"It stands solid and four-square among the structures which are the pride of our New England Venice—our beautiful metropolis won by well-directed toil from the marshes, the creeks, and the lagoons which were our inheritance from nature. The magnificent churches round it let in the sunshine through windows stained with the pictured legends of antiquity. The student of nature is content with the white rays that show her just as she is; and if ever a building was full of light—light from the North and the South—light from the East and the West—light from above which the great concave mirror of sky pours down into it—this is such an edifice. And over all this rise the tall landmarks which tell the dweller in our streets and the traveller as he approaches that in the home of science, arts, and letters the God of our fathers is never forgotten, but that high above those shrines of earthly knowledge and beauty are lifted the towers and spires which are the symbols of all human aspirations, ever looking upward to Him the Eternal, Immortal, and Invisible."

On the library-table, bearing marks that it was not merely a presentation but a well-used copy, was Mr. Sampson Gamgee's book on fractures—a fragment of comfort for my provincial soul.

In the Warren Museum I saw many preparations put up by the hand of Warren himself—a hand the bony elements of which I had the privilege of touching, for with a quaint conceit entirely characteristic of the man he now himself forms part of his own museum. I need not remind you that the book which gave to the world the results of Warren's labors on the pathology of tumors was in some respects an epoch-making contribution to surgical pathology.

Of John Collins Warren, Oliver Wendell Holmes tells us that he was

"A cool and skilful operator, of stern ambition, equipped with a fine library, but remarkable quite as much for his knowledge of the world as for erudition, and keeping a steady eye on professional and social distinction, which he attained and transmitted."

The main building of Harvard University is situated in the town of Cambridge, about four miles from the medical school, and it has been so often and so perfectly described that I need not say anything in repetition, save to speak of the new Memorial Hall, erected as a Valhalla for the alumni who died in defence of the unity of their country. I doubt if throughout the world there is to be found a nobler or more touching or probably more enduring memorial of heroism than the beautiful vestibule of this building, where, upon plain marble slabs, are recorded the names and places of death of the students of arts, law, medicine, and theology, who died in their country's service during the terrible years between 1861 and 1865.

By no means the least striking feature of American medical life is its abundant hospitality, a feature which runs through life generally in the United States. We have here our little medical social clubs, which have the useful functions of promoting good fellowship and a wider culture of professional interests, and very many of us belong to these. But I have never seen this feature of our professional life carried out to the same extent as it is to be seen across the Atlantic. It happened that the night on which I arrived in Boston was the time of one of the monthly meetings of such a club, and I was carried off to meet some fifteen or twenty men, the names of most of whom are well known on this side. There were physicians and surgeons and specialists and general practitioners, full of learning and of the quaintest fun. We started on a small steamer from the village of Waltham, where is situated the enormous factory for watches, and after some ten or twelve miles' run up the river, the beauty of which certainly equalled that of anything of the kind I have ever seen, we were landed at the country-house of Dr. Clarence Blake, where we were entertained right royally. While there I witnessed one of the most effective sights I ever saw, brought about by a fierce storm of lightning playing through the trees of the forest in which Dr. Blake's house is situated.

From Boston I passed on to Montreal, where began the series of engagements for the fulfilment of which my transatlantic visit had been arranged. The beauty of this city has been so often praised that it is useless for me to repeat the platitudes of my own impressions further than this, that in my memory there dwell above all others in prominence the recollections of three landscape views that I have ever seen: from the terrace at Malvern, from Arthur's Seat at Edinburgh, from the castle at Heidelberg, and last, but not least, from the hill at Montreal, from which extends a view all round and not surpassed by anything I ever saw. In Montreal I was the guest of Dr. Gardner, Professor of Gynecology in McGill University, and it was my privilege to give an address to the Canada Medical Association, the annual meeting of which had been arranged to take place during the three days just preceding the meeting of the British Association. My business here, of course, is chiefly with what I saw and not with what I said; but I wish again, here in my own land, to repeat my acknowledgments of the brilliant reception given to me by my Canadian brethren, not so much on my own account as for the position in which they placed me, that of a representative for the time being of British surgery.

During those three days I was associated with some three hundred practitioners of medicine. I heard a number of papers read with discussions upon them, and I say, without hesitation, that nothing which was said or done at that meeting but would have reflected credit on any medical gathering in the world. I often hear it said by practitioners in this country, whose lots are cast in places remote from the busy centres of life, that they find it difficult, or even impossible, to attend meetings of professional societies, and to keep themselves abreast with the growth of the science of medicine and surgery; but in that new country and at that Congress I found men eager and able to be present, though they had thousands, instead of scores, of miles to travel, and it was to me quite impossible to realize the fact that men who sat next me, and who talked fluently and well of the most recent advances in pathology, who knew all the dodges and newest things in laryngology, etiology, and gynecology, practised in villages four, five, or even six days' travel from the place of meeting; that many of them existed in places still unmarked on the map, without any professional neighbor nearer than perhaps

a hundred miles. Some of them were even professors in flourishing medical colleges, placed in large cities, which ten or twelve years ago had no existence. In the style, character, and conversation of these men, not only could nothing be detected which could mark them as being defective in general or professional culture and education, or which could place them in a rank lower than the practitioners of my own country, but I doubt very much if from the highest to the lowest in our own ranks we were to take 250 or 300 of our men at random we could compare favorably with them.

Instances occurred every now and then to me of a most delightful kind, in coming across, suddenly and unexpectedly, faces familiar in college life many years ago—faces of which I had lost all recollection, and of the history of whose owners I had no knowledge at all; men who, tired of the struggles of medical life in the old country, had settled in the new world, and had become prosperous, happy, and successful. One unfailing source of wonderment, which no amount of explanation has as yet made clear to me, is the much larger proportion of practitioners to the population which exists on the American continent compared to what we have here. In England we have about one doctor to 1400 people; in Canada it seems to be about one to 800, and in the States it seems to be about one in 600 or 700; yet they seem to be better paid, to be less hardly worked, to be more prosperous and successful than we are here, and to be in a much better social position than we can boast of. The latter fact, most especially, struck me, and it was proved to me in a great variety of ways. But perhaps I cannot give this impression more clearly than by taking an extract from the speech of a Boston physician recorded at the time of the opening of the new medical school. He gives his impression, as it were, from the other side, and certainly there is a singular concurrence in our experiences. "Dining," he says, "with two Englishmen, a few years since—one an Oxford professor, the other the brother of a lord—I was surprised to hear their views on the social standing of the medical profession, and could not help contrasting their position here, where, if not all autocrats, they are all constitutional, and some of them hereditary, monarchs, accompanied by 'honor, love, obedience, troops of friends.'"

Another source of surprise was the large number of medical schools. Thus, in Montreal, a city of 140,000 inhabitants, there are no less than four of these schools —two Catholic and two Protestant—and, although there is only one of great importance, still all of them are well-officered and well-appointed, and, from what I could see of the results of their training, I am unable to say that any of them can be charged with inefficiency. In Toronto there is a magnificent university, the president of which is the famous archæologist, Daniel Wilson, and two medical schools, the buildings of both of which I inspected with care, and I venture to say that they compare very favorably with the school in our own town, or indeed with any provincial medical school, as well as with a large number of our metropolitan schools. The tendency toward the downward competition which would otherwise be inevitable in medical education is prevented by the establishment of that which we most of all want in this country—a guarantee on the part of the State of a minimum amount of medical education. The only defect of this State control, so far as I could understand it in Canada, is that all the provinces are not agreed as to what this minimum shall be, yet each province seems quite capable of protecting its own interests. At one meeting I heard a very remarkable and exhaustive speech on this subject, made by my friend, Dr. Howard, the dean of the medical faculty of McGill College, and I was very much pained to learn from him that they have to contend in Canada against exactly the same evil influence which we object to here, exercised by a few of the British medical corporations. With so many degree-granting bodies as they have, it is perfectly impossible to expect a uniform quality of education. It happens, of course, that some of the colleges pass inferior men who are rejected by the State Examining Board. These rejected ones are very much in the habit of running over to Great Britain and speedily returning to their native province armed with a parchment granted by one or other of three well-known corporations in this country, all of whom shall for the present be nameless. As British qualifications, these diplomas, I understand, are allowed to override the decision of the State Examining Board, and the mischief which we might well confine to our own borders is carried across the Atlantic. The complaints on this subject are loud and frequent, and they add another to the many strong arguments which we are at present urging in favor of the reform of medical education. Only one other fact concerning this matter needs to be alluded to, and that is that these State Examining Boards, which are practically the general medical councils of the province, though technically appointed by the government, are subject to the universal suffrage of the profession.

Of the hospitals of Canada I can say nothing but what is favorable. Dr. Hingston, the distinguished surgeon of l'Hôtel Dieu, and others, took great trouble to show me all their details. Their appointments are equal in every respect, and in some respects are far superior to those to be seen in any but the newest hospitals in this country. I spent a long afternoon in the hospital at Toronto, and I saw there the results of surgical work as brilliant as any to be found in Great Britain.

Unfortunately, the time of my visit to Canada was such that the schools had not reopened for the winter session, so that I saw nothing of them in actual work.

Of the cities of the States, the first I visited was Albany, the capital of the State of New York, a city famous as being the seat of some of the earliest Dutch settlements. The cities of the United States differ in many marked respects from those of Canada, and many differences quite as striking are to be found in the characters and habits of their peoples, but these differences do not extend into matters affecting my medical notes. In Albany I found two large hospitals —one of Catholic foundation, and the other a public institution—somewhat under State control. I was the guest of Dr. Van der Veer, who is attached to both of these institutions, and he was kind enough to give me opportunities of meeting the staff of both of them and what must be considered by far the greater number of the profession of the city and its neighborhood. Here, as in Canada, I was very favorably impressed with the style of the men I met, and here again was pained by

the fact I have already alluded to, and evident on all sides, that my profession in the States has a social position and influence far greater than it enjoys here.

There is, in Albany, a very large and successful medical school, with about 250 students. There is an abundance of clinical material. The students are a very earnest and well-conducted body of young men, and their professors uniformly give them a character for steadiness and decorum which, perhaps, might excite the envy of some similar bodies here. I had an opportunity of delivering two clinical lectures at this school, and I was asked to perform operations in each of the hospitals, both of which tasks I undertook with very considerable hesitation. In the first place, as I appeared before my medical brethren as a representative of British surgery, and as I never in my life had any opportunity of delivering such a thing as a clinical lecture, I very much feared my performance would prove extremely unsatisfactory, for the delivery of clinical lectures, like everything else, can only be well done by those who are accustomed to it. Our arrangements in England in this particular certainly do seem to be defective, for I could hardly get my American hosts to believe it possible that anyone who has at his command such a mass of material as passes through my hands should never have had one single opportunity of making that material the means of instruction. The operations I undertook with still greater hesitation, for I had so often and so strongly objected to the performance of abdominal operations in large general hospitals, that I could not undertake their performance without laying myself open to grave charges of inconsistency on the one hand, or on the other of subjecting my patients to an unjustifiable risk. It was pointed out to me, however, that I had been invited to America as a sort of missionary, and that in so far as the kind of work I did and its results had been made the subject of misrepresentations and misstatements, it was my duty to emphasize my missionary statements by actual performances, and that this could be done most completely before large audiences of practitioners and students. Further, they argued that the mere performance on this ground of such an operation, under the circumstances to which I objected, would counterbalance and even justify the increased risk to which I believed the patients would be subjected. Upon this specious reasoning I was persuaded to perform a number of operations, with the result that all of them recovered. I am, therefore, somewhat shaken in my belief that the risks are as great as I had asserted them to be, but, on the other hand, as they were all done without the slightest antiseptic precaution, I am more than ever persuaded that ill-results are to be accredited rather to bad surgery than to malevolent germs. One of the cases at Albany was singularly satisfactory, as it included an accurate diagnosis of a solid ovarian tumor and of uterine myoma, and ended in the removal of both. In New York, at the Bellevue Hospital, I had an equally satisfactory effort in being able to diagnosticate and successfully deal with a very typical instance of pyosalpinx.

I need not say that the subject of Listerism was one upon which I evinced much interest and curiosity, and made many inquiries about it amongst my professional brethren in America. Perhaps I may also assume that what I have to say about it will be taken by my hearers with the qualification that as I have now, for over three years, ceased either to accept Lister's doctrines or to follow his practice, and have obtained increasing success thereby, I may be regarded as more likely to collect evidence in favor of my own views than against them.

The statement made, and the rules laid down by Lister and his disciples, have always been so precise, not to say dogmatic, that one of the great difficulties which I always have had in connection with the scheme was that the practice and details recommended were subject to such constant alteration that from month to month there had to be a constant replacement of old plans for new ones, and there was a constant and endless variation in the details of the treatment. This has always seemed to me to be absolutely fatal to any logical discussion of the doctrines upon which the practice is based. If we assume, what nobody can doubt, that specific diseases are produced as the result of the growth within the body of specific entities, and if we can have an assured statement that by chemical or mechanical treatment these living germs, or whatever may be the last word which has been used to identify them, can be destroyed, the whole question of such diseases is brought within the limits of mathematical certainty.

Prevent the access of the disease-bearing entity and the disease will not occur. Nothing can be simpler. But the followers of Lister proceed a little further; they assume that cases of death after operations have specific characters as clear and distinct as those, for instance, of scarlet fever and smallpox. And from this assumed analogy, and upon this assurance, they base their establishment of all the infinite and increasing variety of processes for the destruction of the wicked germs. But from my point of view I fail to see the analogy which is assumed. I have, for years, been struck with the fact that the conditions under which patients die after operations assume such endlessly varying forms that I have come to the conclusion that any doctrine, which takes for granted that these conditions can be so grouped as to build up forms of specific disease, is based entirely upon insufficient observation and inaccurate knowledge of the facts. This view has obtained a stronger and stronger hold upon me as my experience in my special line of practice has accumulated; watching cases from time to time that had done badly, I am satisfied that hardly two of them died in precisely the same way and from precisely the same cause, and I am, therefore, profoundly convinced that to assume that every patient, or, at least, the majority of the patients, who die after abdominal section succumb to some septic peritonitis, or some septic something or other, is only to cover our ignorance with a cloak, and to bar the way for real advance.

I do not think that any contribution to the literature of abdominal surgery has done so much harm as that column in Sir Spencer Wells's book, in which a terribly long series of fatalities is ascribed to "septicæmia" and "septic peritonitis." Some of Sir Spencer's deaths are put down as having occurred from "peritonitis" simply, but throughout the book, from board to board, there is not a word which explains the different use of these three terms. I should like immensely to be told how a pathologist is to discriminate between peritonitis that is septic and peritonitis that is not, and it is of the utmost

importance that such a difference should be clearly defined, for it is the merest folly to put up a theory and then distribute manufactured instances around for its sustenance, as has been done by Sir Spencer Wells.

I do not mean to say that there may not be specific germs which may be conveyed into the abdomen of the patient by accident—germs which may kill the patient; but I do say that the evil influence of Lister's teaching has been over and over again instanced in the constant tendency shown by too many of his disciples trying to cover faults that could be avoided, and bad surgery that might be improved, by attributing the disaster arising from them to a supposititious germ. The conclusion of this part of what I want to say is this, that after innumerable statements that this plan, that detail or the other substance, an all-permeating spray, a piece of lac plaster, or a mass of thymol gauze, or eucalyptol, form irresistibly destructive agents for the germ, we have the astounding fact that one after another of these nostrums are given up, declared to be inefficient, something new is advanced, in its turn to be discovered as a fraud, and thus year after year the process is repeated.

It is somewhat curious, that since this was written, I have read the address of Sir Joseph Lister, at the Clinical Society, in which he admits having twelve months ago expressed "an overweening confidence" in his previous agents, and now he recommends an ingeniously concocted mixture of blood-serum and corrosive sublimate with a confidence as great, and probably as overweening, as in previous instances. This constant over-confident advance and humiliating retreat is quite enough, if no other argument were needed, to show the fallacy of the whole thing.

These were the views which, in very many instances, I laid before American surgeons, and I did not find in a single instance that the facts could be disputed. Among all with whom I talked, I found only one who still used what I suppose I may, without any disrespect, call the old-fashioned carbolic method, the spray and protective and solution, and plasters and gauze. So far as I could discover, the day of that sort of thing on the American continent is rapidly coming to an end.

Our transatlantic cousins are greatly infected by German methods of proceeding, and I understand that the last new germicide is corrosive sublimate. A large number of the American surgeons now perform their operations under an irrigating stream of a very weak solution of this salt; but they are by no means agreed, either as to the strength of the solution required, or of the completeness with which it should be used. One of the most distinguished of American surgeons told me that he is now quite satisfied that sponging over the wound after the operation is completed with a 1 to 1000 solution is all that is necessary, and he states that his results are quite as satisfactory in every way as when he used the cumbrous, expensive, and troublesome method involved in the use of carbolic acid. If it were worth while, I might enlarge in detail upon this subject by giving some transcripts I made of detailed views as expressed by individual surgeons, but perhaps it would not be fair to those with whom I conversed to give their statements without having warned them in advance that I was of a mind to make public use of them. The statement which most impressed me was that of a professor of clinical surgery of more than thirty years' standing, a man of enormous experience, and attached to one of the largest hospitals I visited, who told me that his deliberate conviction had at length been formed that the so-called antiseptic system of surgery had little to commend it, save that of being a very successful system of quackery.

This is a pretty strong term to use concerning a doctrine and practice which has so many and such important followers; but I am bound to say he seemed to me to have some kind of justification in very much the line of argument which I have already indicated. He put it very much in this way: that if, from time to time, in every few months the methods are changed, and with each succeeding change strong statements are made that the last development contains the only security, it must inevitably follow that to the public mind there can be security only in the hands of the inventor himself for the complete and successful accomplishment of details. Others must be in the shade; for whilst they are following methods which Sir Joseph Lister himself has by that time discovered to be useless, he himself is on a new road in which success for the time at least is secured.

This may or may not be an uncharitable view; but coupled with the oft-repeated statement, that the antiseptic practice can be successfully followed only by believers of antiseptic doctrine, it leads very much to conclusions which I have already sufficiently often expressed in public to require repetition here.

The next city that I visited, was one famous in the annals of all historical affairs in the new country—I mean Philadelphia—and no place in the United States can give a better idea of the enormous progress which has been made in America in every phase of life. When I reached that city the medical schools had opened, and I was able to see them at work. I was invited to lecture and demonstrate in the Jefferson Medical College, and was honored by a very large audience of practitioners and students. Here, as elsewhere, I can say nothing but in praise of the style and appointments of both schools and hospitals; perhaps of all the schools which I visited, the one which struck me most is the Women's Medical College of Pennsylvania, which issued in May last its thirty-fifth annual announcement. It has a body of teachers, twenty-three in number, of whom a few belong to our own sex; but it is worth while saying that the demonstrators of anatomy, surgery, practice of medicine, and obstetrics are all ladies, and the professor of obstetrics is Dr. Anna E. Broomall, who favored me with a visit here last year. The building in which the school is conducted, is very large and splendidly appointed, and attached to it there is a large general hospital, with lying-in wards. The staff of this hospital is entirely feminine, and in its theatre all the operations of surgery have been successfully performed by lady surgeons. Last year twenty-six degrees of doctor of medicine were granted by the faculty; and from the perusal of the curriculum, as well as conversation with some of the graduates, and by discussion of the merits and demerits of the whole question with some of its friends and some of its opponents, I am quite satisfied that the lady graduates of Philadelphia are quite as carefully trained as those in any other medical school. When I tell you that last winter one hundred and thirty-two students matriculated in this

school, that the theatre in the hospital is large enough to hold three hundred sitters, and that about four thousand patients every year pass through the hospital, I think I shall have said enough to prove to you that in the United States at least the practice of medicine by women has become quite an accomplished fact. There can be no doubt from what I heard from their male competitors, that large numbers of these women succeed in securing a fair share of public confidence. Unfortunately, although they have received a much fairer share of assistance from their medical brethren in America than their sisters have here, their path has not been quite free from obstruction, and in many parts of the States they are not yet admitted to the equality of professional position which I have always claimed as their right. Yet I must say, on behalf of the medical men in America, that they have behaved far more generously to women desiring to study and practice medicine than we have in this country. On both sides of the Atlantic the prejudice against them, altogether unnecessary and entirely without justification, is slowly passing away, and I hope ere long to see measured out for them everywhere that justice to which their claims entitle them.

The views which I personally expressed in a paper read before my professional brethren in this town twelve years ago have received ample justification from my experience in Philadelphia. These views at the time brought down upon me words of the strongest condemnation. I might repeat them here, but I prefer to take them as expressed almost completely by Dr. Oliver Wendell Holmes, in the address I have already quoted:

"I have always felt that nursing was rather the vocation of women than general medical and especially surgical practice. Yet I myself followed a course of lectures given by the younger Madame Lachapelle in Paris; and if here and there an intrepid woman insists on taking by storm the fortress of medical education, I would have the gate flung open to her as if it were that of the City of Orleans, and she were the Joan of Arc returning from the field of victory."

I do not think that any other point to which I might call attention would justify me in repeating an account of details which would present but slight variation; and the only other incident of which I may speak, was my visit to Washington, where I had the privilege, with the help of the Surgeon-General of the United States Army of seeing one of the most wonderful medical institutions in the world. Of course, I allude to that immense library, formed but always forming, at Washington, and one of the results of which comes before us in that colossal catalogue, which is one of the best proofs of the advancing civilization of the great Republic. You are all familiar enough with the *Index Medicus*, the work of Dr. Billings and his assistants, and any one familiar with the business of cataloguing must know what labor that represents; but if you could see the library itself, your impressions of the undertaking would be immensely increased. The building in which it is situated is the old theatre, hallowed by the occurrence in it of one of the most dramatic incidents of modern times—the assassination of Abraham Lincoln. The building contains also a large museum, devoted mainly to the exhibition of specimens of surgery resulting from the use of all kinds of warlike weapons; and there are exhibited the ghastly result of the War of the Rebellion; every conceivable injury inflicted by lethal methods is collected. Gunshot wounds of bones form one of the most extraordinary sights I ever saw in my life, and some of the specimens have an attraction not merely of a surgical character. Thus I saw the cervical vertebræ of Lincoln's assassin, split by the bullet which reached him in his hiding-place; and the pathological collection aptly includes the brain of Charles Guiteau, who murdered President Garfield.

My trip ended in New York, where I met with a reception, from the leading members of the profession and from many distinguished laymen, of the heartiest and most friendly kind. I lectured and operated at Bellevue Hospital before a very large audience, and I was taken round several of the other medical institutions of the city. Here, as everywhere else, I was immensely impressed with the hospitable friendliness of the people; and in conclusion, I can, I think, say that if any one here requires to be persuaded that the Anglo-Saxon race and the Anglo-Saxon tongue are destined to be in the future as they have been in the past, the dominant influence of the world, he must do as I have done, and put it within his power to write a similar rambling tissue of American Notes.

ORIGINAL ARTICLES.

SOME OBSERVATIONS ON THE USE OF THE HYDROCHLORATE OF COCAINE, ESPECIALLY ITS HYPODERMIC USE.[1]

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HYDROCHLORATE of cocaine is a drug evidently of such power that, on reading the effects produced on the eye, I determined to investigate its properties in other respects, with a view of ascertaining whether it might be of use to the physician as well as to the ophthalmologist. I shall first detail some conclusions I have arrived at with reference to its *local* action.

On the *throat* it undoubtedly diminishes the sensibility, and is serviceable in causing the laryngoscope to be better borne. Moreover, it is of use in irritable relaxed throats, and in instances in which there is spasmodic difficulty in swallowing associated with this irritability, or from other causes. In ulcers at the back of the throat, connected with dysphagia, painting the parts two or three times daily affords considerable relief. Only for this to last, the solutions employed must be stronger than those which have been used—not from two to four, but from eight to twelve per cent. In tubercular laryngitis the action is excellent. Even a four per cent. solution gives hours of relief, in some cases as many as six hours' freedom from the sense of irritation and the difficulty of swallowing; and stronger solutions relieve for a longer time. The result obtained is far more certain and decided than from the local use of morphia. Compared with iodoform, it is proba-

[1] Read before the College of Physicians of Philadelphia, December 3, 1884.

bly less permanent, but as good, or better, at the time.

Dr. Jurist, whom I asked to employ the hydrochlorate of cocaine at the throat clinic of the Jefferson Medical College, has favored me with a note, in which he speaks of the remedy being "brilliantly successful" in relieving pain and making deglutition easy in painful diseases of the pharynx and larynx, preëminently in tuberculosis and in syphilis.

Using chromic acid and the galvano-cautery frequently, he found that, by first painting the parts with a four per cent. solution, the employment of these agents could be made comparatively painless, and that the efficacy of these, or indeed of all caustic and destructive means, is not interfered with.

In syphilitic ulcerations especially this was tested, and much suffering prevented. Where only four per cent. solutions are employed, the patient may not feel the caustic application to the abraded surface for about twenty to thirty minutes, but after this it becomes painful. All trials should be preceded by careful cleansing of the parts. The local action of the cocaine is also astringent and hemostatic as well as one destroying sensibility. This local action may also be perceived on the tongue and gums. "Although facilitating intralaryngeal medication, it does not prevent spasms," Dr. Jurist writes me, "and consequently is valuable in intralaryngeal operations only on account of its anæsthetic effects."

As regards the local use of cocaine on other portions of the body, I am able to record some observations made in my ward at the Pennsylvania Hospital. In one instance pain in a hollow molar tooth was speedily relieved by inserting a piece of cotton saturated with a four per cent. solution. It may in passing be remarked that cocaine used hypodermically in the same patient failed to mitigate an attack of intestinal pain of colicky kind which had lasted for two days. A case of earache which seemed to be neuralgic was at once relieved by instilling a few drops of a four per cent. solution into the meatus; and a similar observation was made by the resident physician in the ward of my colleague, Dr. Hutchinson. As regards facial neuralgias, the results were less decisive than anticipated. Perhaps they would become more so if we were to rub in an oleate of cocaine over the aching nerves, or larger nerve trunks; or to use a hypodermic for its local use where the disordered nerves are superficial and easily reached. In one instance of neuralgia of the face in which the pain shot into the jaws, painting the gums of the upper jaw with a four per cent. solution, gave very speedy relief. For the amelioration of painful and irritable affections of the nasal mucous membrane, hydrochlorate of cocaine, in not less than a four per cent. solution, is of use; and I have known applications with caustics made without pain when the membrane, after being well cleansed, had been painted with the solution. Since becoming acquainted with the action of the remedy, I have had no case of rose cold or hay fever. But it ought to be of service, and I would suggest its employ in these most troublesome affections.

While discussing its local use it may not be inappropriate to refer to the fact that the solutions of the hydrochlorate of cocaine we all employ—Merck's hydrochlorate, contain less of the alkaloid than supposed; a four per cent. solution, for instance, is only of about three per cent. strength. My attention was called to this by Dr. Jurist, whose remarks, speaking of his observations, I append; and while writing these lines I find that Dr. Squibb has just published the same conclusion:

"The difficulty experienced in obtaining the cocaine hydrochlorate in bulk, while the solutions were always at command, made it seem desirable to study the latter more closely. In conjunction with my friend, Mr. Stedem, a number of examinations were made. Our later investigations included Merck's manufacture in bulk.

"Experiment I. On adding a dilute solution of ammonia to a solution of the cocaine salt, and then agitating with chloroform, the ammonium hydrochlorate could readily be drawn off with a pipette, leaving the cocaine in solution in the chloroform. By carefully evaporating both solutions the ammonium salt was readily obtained in pure crystalline form. On the watch-crystal into which the chloroform solution was poured there was formed a number of *white acicular crystals surrounded by an areola of sticky, resinous material*, light-yellow in color, and altogether amorphous in character. The crystals were soluble in hot and cold water; the resinous product in dilute *hydrochloric acid*, but not in water.

"Experiment II. Another portion of the solution was carefully evaporated over a water-bath. The resulting mass was similar in appearance to the first, but was readily soluble in water. The difference in solubility is accounted for by the acid state of the residue. When it is remembered that cocaine and its salts have heretofore been described as colorless and crystallizable, and that Merck's product is amorphous granular, and of a light straw color, and further, that chemical manipulation separates a resinous mass from the commercial article, the proposition that our present solutions do not contain the full proportion of the active principle appears to be well grounded."

But what has interested me much about the drug, and what, so far as I know, has not been as yet investigated, is its hypodermic employ, elucidating its general action. In the observations I am about to detail, I have been greatly aided by Dr. Ecroyd, the resident physician in my ward at the Pennsylvania Hospital, and by Dr. Woodbury. We have tried the remedy both on the well and the sick, especially in cases of neuralgia and other painful affections, and have arrived at certain definite conclusions. But first let me speak of the dose. We began with one minim of a two, then of a four per cent. solution, only to find them inert. No influence could be detected on pulse, respiration, or temperature; nor was any local anæsthesia produced at the point of injection. Indeed, no decided effects are produced with less than eight minims of a four per cent. solution, or one-third of a grain of the hydrochlorate of cocaine; and half a grain will show these effects even more strikingly. In some instances, two-thirds of a grain were used.

As regards the local influence at the point of injection, there is considerable difference whether a superficial or a deep hypodermic be used. A hypodermic thrown into the superficial layers occasions local anæsthesia, so that the part may be pricked

with needles without these being felt. In one case in which we tried one of these superficial injections in a boy of nineteen, a wheal was produced which was quite insensitive, while all around it sensation was preserved, though perhaps slightly reduced. It is evident, therefore, that if it be desirable to use the hypodermic means of producing local insensibility for the removal of small tumors and the like, a superficial injection immediately into or very close to the parts to be removed will have to be practised. These superficial injections do not occasion subsequent inflammation or abscesses. This is equally true of deeper injection into the tissue below the skin; in the manner in which hypodermics are generally given. But the deeper injections do not produce local anæsthesia of the surface.

Now, as regards the *general* effect of hydrochlorate of cocaine hypodermically employed, it has a little, but not very much, influence on *sensation*. Most patients speak of a sense of warmth all over the body, which, beginning at the point of injection, becomes general in from five to ten minutes; it is, however, not of long duration, the arm in which the injection was practised feeling numb or heavy, or, as one expressed it, "funny." In him, half a grain having been thrown into the left forearm, the sensibility of the skin was diminished from the elbow down to the fingers on that side, and two sharp points were not as distinctly as previously distinguished at the tips of the fingers. There was no change of general sensibility in the legs. The mucous membrane of the lips, tongue, fauces, was slightly less sensitive to sharp points; the conjunctiva was less sensitive, the pupils were dilated.

On the whole, then, there is some general reduction of sensibility, though it is not marked, and is transitory. And this observation accords with others in which one-third of a grain was used, where the alteration of sensibility showed even less; and with a few in which two-thirds of a grain were employed. The general sensibility is therefore only slightly altered.

On the *temperature*, the effect is to heighten it somewhat. This is the record taken by Dr. Ecroyd in the case ofa well-nourished man suffering from pains in back and gluteal region, seemingly due to muscular rheumatism:

One-third of a grain of hydrochlorate of cocaine was used; no local anæsthesia was produced at the point of injection, and there was no influence on the pain.

At 11 A.M. (just before injection), pulse 76; resp. 17; temp. 97.5°.

At 11.25 A.M. (after injection), pulse 70; resp. 16; temp. 98.5°.

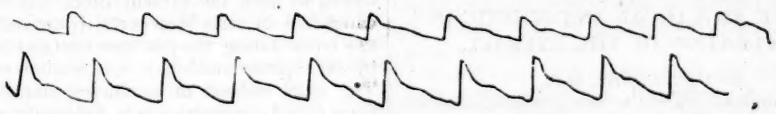
At 11.40 A.M. (after injection), pulse 66; resp. 16; temp. 98.5°.

At 11.55 A.M. (after injection), pulse 64; resp. 17; temp. 98.4°.

At 12.10 P.M. (after injection), pulse 68; resp. 16; temp. 99°.

Similar observations were made in other cases; and it may, in general terms, be stated that the temperature rises from half a degree to a degree and a half; that it does not do so abruptly; but that the rise is maintained for several hours. Within ten minutes after the injection has been given, an increased heat is registered. In one case it was four-tenths of a degree above the figure of starting, and it never reached more than half a degree, which it did one hour and five minutes after the hypodermic injection of one-third of a grain.

The most striking effect of the hypodermic injection of cocaine is on the *circulation*. The pulse may be somewhat accelerated or slower; but it always becomes fuller and stronger. The frequency of beat was noted to fall from 66 to 54, twenty minutes after the injection. In other instances, there was but little variation; in a few, a slight quickening was detected. But not in a single instance was there not a fuller and a stronger pulse. We made many observations on these points at intervals of fifteen minutes, the sphygmograph being kept in place to insure uniformity of pressure, and always with the same result. I select from numerous tracings this one tracing, taken in a case in which half a grain of the hydrochlorate had been given hypodermically; the upper line is the pulse-trace before the injection, the lower fifteen minutes after. The higher vertical line of ascent, the more pointed summit, show the increased force of cardiac contraction; the more sudden fall in the line of descent, and the well-marked dicrotic wave, indicate no increased, rather lessened—arterial tension. And all our observations tend in the same direction. Tracings taken an hour after the injection still show these characteristics; but the effect gradually passes away. While marked, there is decided increase of the heart's action; the apex beat is more distinct and forcible.



On the *pupils* the influence is very marked. They become speedily dilated; and with the change, uncertainty of vision is complained of. The dilatation of the pupils, following the hypodermic injection, does not last more than a couple of hours, and during this period ophthalmoscopic examination is of course very easy.

On the *secretions*, I have not as yet fully studied the drug. On the bowels it had no influence; the urine appeared increased in quantity, and the specific gravity decidedly lowered, while the phosphates were found to be increased. But our observations were not very numerous or definite on these points.

Summing up now some of the general effects observed, the drug, used hypodermically in the doses mentioned, failed to relieve attacks of intestinal pain, and was useless in cases of obstinate neuralgias, especially in sciatica. This was especially shown in a case at the Pennsylvania Hospital, in which about

ten hypodermic injections were given, varying between one-third and half a grain, but in which no decided effect on the pain or the disease was produced. It is, however, fair to state that the case was of a year's standing, and had resisted blisters and chloroform injections. The cocaine influenced somewhat the dull pain; but did no permanent good. Neither in this case nor in others did it induce sleep. In certain very superficial neuralgias, its local action, not its constitutional influence, does temporary good. As an anæsthetic, its local action is the one which will give it its great value; and in diseases of the eye, ear, throat, tongue, and nose, the insensibility to which it gives rise suggests a wide range of application. But this insensibility cannot be produced to a sufficient degree through the constitutional effect of a hypodermic.

Yet thus resorted to, the remedy has other and valuable uses. The effects on the pulse and temperature recorded in these observations, suggest its application in many a condition of collapse, of weak heart, or heart failure; and its employ in low fevers, too, as a cardiac stimulant is a self-evident proposition. How permanent the benefit, how often the doses must be repeated, are matters which experience alone can determine.

COCAINE AS A LOCAL ANÆSTHETIC IN ENUCLEATION OF THE EYEBALL.

BY D. C. COCKS, M.D.,

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ON the 8th of October, 1884, the hydrochlorate of cocaine was first used in America in ophthalmic practice by Dr. Charles S. Bull, of New York. Since that time almost every operation that can be done upon the eye has been done under its influence. Ether, nitrous oxide, and chloroform have been used but seldom by those surgeons who have been fortunate enough to have a supply of the *pure* drug. I first used a two per cent. solution of the alkaloid on the afternoon of Monday, October 13, 1884, and have only used ether for its pure anæsthetic properties once since that time (*i. e.*, in a case of incipient panophthalmitis, in which the bulging eyeball prevented the use of the eye-speculum until ether was used).

At first sceptical as to its powers of producing anæsthesia deeper than the conjunctiva and the cornea, I limited my operations to these localities; but as I saw my *confrères* doing iridectomies, extractions of cataract, tenotomies, etc., I followed their example, and soon had abundant reasons for becoming more and more enthusiastic in regard to its wonderful powers. I (as others have done) was enabled to do iridectomies without giving pain; and it might be well just here to state how it has been used to accomplish this result, because the failures in its use have been in most cases from want of care in this particular—anæsthesia of the conjunctiva and cornea having been produced by dropping two or three drops of the two or four per cent. solution on the cornea, then waiting three to five minutes and repeating the application. This is done three or four times; by this time complete anæsthesia will be found. Section of the cornea now being made, it is necessary to introduce the solution into the anterior chamber. This can be done either by injecting it with a syringe or by introducing a spatula through the wound and thus conducting the solution from the dropper to the iris. In a few seconds the iris can be withdrawn and the cut painlessly made. One great advantage of its use, referred to by several writers, is the facility with which the dressing of the wound can be accomplished, clearing it of blood-clots, iris tissue, lens material, or vitreous.

Perhaps the severest trial to which this local anæsthetic can be put is enucleation of the eyeball. Several attempts to do this have been made, but, so far as I have heard, unsuccessfully. I therefore give a short account of an enucleation done November 29th at the New York Eye and Ear Infirmary, the anæsthetic being cocaine.

Mr. M. W., æt. 50, entered my service at the New York Eye and Ear Infirmary November 26, 1884, with a phthisical eye (right) having plus tension and being very sensitive to the touch. He stated that the right eye was lost in infancy, cause unknown, and had never bothered him until four weeks ago, when it suddenly became inflamed (?) and has continued so until the present time. As the left eye, which had formerly been perfectly normal, had gradually failed during the past months (no change shown by the ophthalmoscope), enucleation was advised. The usual method of producing anæsthesia of the cornea and conjunctiva was followed; then having incised the conjunctiva on the temporal side I separated the subconjunctival tissue as far back as possible with my scissors and a probe, and with an Anel syringe injected a few drops of a four per cent. solution over the tendon of the external rectus.

I then divided this tendon, and introducing the point of the syringe as far back as possible, keeping its point near the globe, I injected a few more drops; this was done with each of the recti. The globe was then dislocated forward, the nerve severed, the obliques cut, and the conjunctival wound loosely drawn together with a stitch. During the operation the patient lay perfectly motionless and without any acceleration of pulse; occasionally he felt slight pain, but not enough to interfere with the operation—and indeed complained most when the cavity was flushed with the cold solution of boracic acid previous to applying the compress and bandage.

The operation lasted about one-half hour, and during that time the solution was dropped on to the eye, or injected into the orbit, every three to five minutes. The patient, when asked afterwards in regard to the pain of the operation, replied: "I suffered much more before the operation than during it." There were no after-effects noticed (although carefully watched for by Dr. Walker, the House Surgeon) from the large amount of the solution (representing about four grains of the cocaine) injected into the tissues of the orbit.

The cocaine used in this case, and in most of the operations at the Eye and Ear Infirmary during the past month, was made and dispensed by David

Hays & Sons, of 543 Fifth Avenue, New York City. The solution possesses the anæsthetic as well as the mydriatic properties of cocaine, but differs from the solution of Merck's crystals in being slightly irritating when applied to the conjunctiva. The solution made by Parke, Davis & Co. is also slightly irritating. The wound healed kindly, and the patient was discharged from the Infirmary December 6, 1884.

The points of interest to me are:

1. That the solution was applied to the surface of the eye every three or four minutes during the operation.

2. That the injections were made not only over the tendons, but also deep into the orbit behind the eyeball.

3. That the operation was done slowly so as to allow the cocaine to act thoroughly.

4. That about ʒiss of a four per cent. solution was used.

5. That no physiological effects followed the use of so large a quantity of the drug.

6. That the field of usefulness for cocaine has become so wide.

MEDICAL PROGRESS.

TREATMENT OF UNREDUCED SPONTANEOUS DORSAL DISLOCATION OF THE HIP.—At the meeting of the Royal Medical and Chirurgical Society on October 28, MR. WILLIAM ADAMS read a paper on Excision of the Head of the Femur in a case of Unreduced Spontaneous Dorsal Dislocation occurring during Fever. The case was an example of spontaneous dislocation of the head of the femur on the dorsum ilii, occurring during the progress of rheumatic fever in a boy eleven years of age, and as the limb remained in a contracted and useless condition, the head of the femur was excised on March 29, 1882. This operation had been first performed in a similar case by Dr. H. G. Rawdon, of Liverpool, on July 16, 1881, and published in the *Liverpool Medico-Chirurgical Journal*, January 2, 1882. In Mr. Adams's case, the patient was admitted into the Great Northern Hospital on March 4, 1882. After two unsuccessful attempts at reduction, having previously divided the adductor longus tendon, Mr. Adams excised the head of the femur by making a T-shaped incision with the long arm two inches and a half in length directly over the head and neck of the bone, and the small arm one inch in length, transversely over the head of the bone, which was at once exposed. The head of the femur was uncovered by capsular ligament, and the articular cartilage was in a healthy condition. It was found that the capsular ligament had been ruptured, and the torn margins of the rent passed on either side of, and closely embraced, the neck of the bone. After dividing the margins of the capsular ligament, the operator passed his small subcutaneous saw to the neck of the bone, and cut through it a little below the margin of the articular cartilage. The detached head of the femur was then drawn out of its position after some slight adhesions had been cut through. The round ligament preserved its normal connection with the head of the bone, and was adherent to the articular cartilage, having been divided with the saw a little below the head. The wound progressed favorably without much suppuration, and on June 1 was completely closed. On June 14, the patient was allowed to walk on crutches, and on October 1 without crutches. The limb was perfectly straight, and the movement at the hip-joint was free in all directions. The author observed that in all the cases of spontaneous dislocation which had fallen under his observation, the head of the femur had been dislocated on to the dorsum ilii. The cases were arranged in three classes: 1. Dislocation occurring during the progress of fever. 2. Dislocation occurring in cases of paralysis, generally infantile, but occasionally in the adult. 3. Dislocation occurring in the first stage of hip-joint disease without suppuration. Excision of the head of the femur in its simplified form, as above described, the author believed, would be found applicable to all these cases, unless sufficient freedom of motion be obtained by tenotomy and passive movements. He also thought it might be applicable to some cases of fibrous ankylosis of the hip after disease in which the limb remained contracted, as free motion is seldom obtained by simply dividing the neck of the bone.—*Lancet*, November 1, 1884.

ANTIPYRIN IN DISEASES OF CHILDREN.—In an article on this subject DRS. PENGOLDT and SARTORIUS state that antipyrin is easily soluble, and the taste easily disguised, so that it may be administered to children in an agreeable form. They have used it in 21 cases of fever in children of different ages, in 18 cases of pneumonia in children, and in 1 case each of erysipelas, scarlet fever and diphtheria.

In the cases of fever gr. jss–iij were given for each year of the child's age; these doses having a marked antifebrile action for from 4 to 8 hours, though the temperature was not reduced entirely to the normal. The drug may be administered in syrup. It acts very well when given per rectum.—*Centralbl. f. d. gesammte Therap.*, Sept. 1884.

DOUBLE CAROTID ANEURISM; LIGATURE OF BOTH VESSELS.—The *Cincinnati Lancet and Clinic*, of October 18, 1884, gives an account of a case reported by RIEGNER (the reference not stated). The patient, a male, æt. 54 years, consulted Riegner in 1881, for the relief of a pulsating tumor on the left side of the neck, which had appeared during the past six weeks. The tumor was growing rapidly. It could not be attributed to an injury or a specific taint. It had all the pathognomonic signs of an aneurism. When the artery was compressed between the two heads of the sterno-cleido muscle the growth, which was about the size of an egg, became very much smaller, and pulsation and bruit ceased entirely. The carotid on the opposite side presented no abnormalities at that time; the radial pulse was synchronous on both sides. The pulse of the left temporal artery was somewhat tardy when compared with the opposite side. Digital compression was ordered made for four or five hours for four consecutive days, and the patient was put on a low diet, with iodide of potash internally and an ice-bag on the tumor. The growth diminished in size, but the patient was compelled to make a journey, during which time it rapidly increased in size again to such an extent as to make pressure on the trachea and œsophagus, causing difficulty in deglutition and phonation.

The common carotid was ligated according to Bruns's

method. Two strong catgut ligatures were put on about one centimetre apart; the artery not divided. The growth disappeared and ceased to pulsate. Marked cyanosis of the face set in, which always disappeared in the latter part of the day. Pupils were the same on both sides, nor were there any untoward symptoms whatever on the part of the brain. The wound was dressed with the permanent antiseptic dressing and a decalcified bone drainage-tube. There was no reaction, and the dysphagia and hoarseness soon disappeared. When the first dressing was changed, thirteen days after the operation, the wound was found to be perfectly healed; the sac was about the size of a small coin, flat, solid, without any pulsation, and in the period of two weeks more all signs of a growth had disappeared. In the lower third of the neck an artery, about the size of the radial, quite superficial, developed rapidly, which was undoubtedly the collateral branch. The pulsation of the external maxillary and temporal on the left side had ceased entirely. In the course of a year the patient consulted Riegner again for a heavy feeling in the right side of the neck. The carotid was pulsating abnormally strong, otherwise there were no abnormal organs. One-half year later a tumor about the size of a pigeon's egg had developed in the region where pain was formerly complained of. During his absence the patient was treated at Vienna with ergotin injections, but with no results. The condition of the growth remained stationary for six months, when it again increased rapidly in size, and Riegner was once more consulted, and found an aneurism on the right side, eight and one-half centimetres long and seven centimetres broad. The sac crowded the trachea to one side, and moved up and down with it during the act of deglutition, as though there were adhesions existing between the two structures. The patient was quite cyanotic and very much depressed. Compression of the carotid caused a cessation of the pulsation in the sac, but, in the course of a few seconds, the patient complained of dizziness and extreme cyanosis, but finally the pressure from an ice-bag was tolerated for five minutes. April 5th, the right common carotid was ligated, the artery was somewhat displaced, and the sternal end of the cleido muscles had to be severed. The artery was so much affected that only two and one-half centimetres of the lower portion was healthy. It was ligated in this portion with No. 3 sublimate catgut in two different places, but the vessel was not severed between the ligatures for fear that they would slip. Pulsation in the sac ceased at once, but it did not collapse. The pupils, at first narrowly contracted, soon dilated ad maximum, and finally the right pupil contracted somewhat again, leaving a difference between the two. Dangerous cyanosis set in, but in the course of twenty minutes it passed off again, The dressing consisted, as before, of the immovable antiseptic wood-wool. When the patient recovered from the anæsthetic he did not complain of any brain symptoms, the radial pulse was full at 75 per minute. The patient was dismissed cured on April 23d.

POST-PARTUM AVULSION OF THE UTERUS.—At the meeting of the Obstetrical Society of London, on October 28, MR. J. HOPKINS WALTERS read a paper on this subject, with a case followed by recovery. In April, 1882, Mr. Walters was called to a patient, aged twenty-two, in her third confinement. She had been attended by a midwife, who, after the birth of the child, finding that the placenta did not come away, pulled at the cord, which broke at its attachment. She then introduced her hand and tore away the whole of the uterus with the right ovary and Fallopian tube, portions of the round ligaments, left Fallopian tube, and ligament of the left ovary attached to it. Mr. Walters saw the patient twenty-one hours after the accident, and found her under the influence of opium, and somewhat recovered from severe collapse. A large quantity of omentum protruded from the vulva, and in the upper part of the vagina was an enormous rent. Mr. Walters ligated and cut away the omentum, which was cold and badly bruised, at the level of the vulva; the parts were washed with solution of permanganate of potash, and a pad of salicylated wool applied. The opiate was continued; catheterization ordered every eight hours, and the diet limited to milk and beef-tea. The patient did well until the fifth day, when she was seized with shivering; her temperature fell to 97.4°, and the pulse rose to 170. Mr. Walters irrigated the vagina with solution of permanganate of potash, and, finding that the vaginal fundus had well closed round the omental stump, afterwards used a solution of carbolic acid; quinine, in large and frequent doses, was combined with opiates, and the vagina syringed every eight hours. On the twenty-eighth day the patient was able to drive five miles to the Royal Berkshire Hospital, where she remained under Mr. Walters's care until the beginning of July, when the omental stump had frittered away, and the vaginal wound was perfectly cicatrized. At the present time, two years and a half after the mutilation, the patient is in perfect health and attending as usual to her ordinary occupations. After a diligent search, Mr. Walters has found reports of thirty-six cases of accidental removal of the puerperal uterus, of which fourteen recovered. Of all these, only three were, without doubt, unattended by previous inversion of the uterus. Having regard to the medico-legal aspect of these cases, Mr. Walters draws an important distinction between the accidental removal of the previously inverted uterus and of the uterus that has not undergone inversion, on account of the possibility of uterine separation through spontaneous rupture. According to present experience, inversion of the uterus is not found to coexist with rupture either of that organ or of the vagina; and where it is shown that the uterus was inverted before being torn away, it becomes tolerably easy to estimate the degree of criminal responsibility attaching to the attendant. On the other hand, where it can be proved that the uterus was never inverted, it is impossible to assert that the separation of the uterus was wholly due to violence, and not contributed to by a spontaneous rupture through the uterine or vaginal walls. Mr. Walters quotes cases and authorities to prove the occasional insidious occurrence of uterine rupture, the suspension of symptoms, and the completion of childbirth in spite of it, in some cases independently of manual interference, and without any disproportion between the maternal passages and the child; and concludes that, in giving evidence in such cases, these facts should be most carefully remembered.—*Lancet*, November 1, 1884.

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SATURDAY, DECEMBER 13, 1884.

THE TREATMENT OF CYSTS OF THE THYROID GLAND.

THE treatment of the solid varieties of struma or goitre appears, after the failure of the internal administration of iodine, to have narrowed itself down to extirpation. This is not only the most reliable measure, but under antiseptic precautions and improved methods of operating in the hands of surgeons who have had the most experience with strumectomy, it is now recognized as a comparatively safe and eminently proper procedure when there are urgent reasons for its performance.

The best treatment for cystic goitre, or, more correctly speaking, of solitary cysts of the thyroid body, is as yet an open question. In a discussion upon this subject at the Versammlung Deutscher Naturforscher und Aerzte in Freiburg, in 1883, which may be found in the *Centralblatt für Chirurgie*, No. 44, of that year, Maas, Kraske, and Beck strongly urged incision of the sac, with or without suturing its edges to the edges of the skin wound, and packing with lint. Of 11 cases thus treated all recovered, but there was alarming hemorrhage in 1. The procedure, however, if the wall of the cyst happens to be thick, or the seat of calcareous deposits, or if it is constituted in part, as it not infrequently is, by degenerated glandular tissue, requires a long time for a cure, and is liable to be followed by the formation of a troublesome fistule. Nor is it a perfectly safe measure, as of 100 cases treated in Freiburg, in 1879, and analyzed by Schinzinger, 3 died, while of 11 from the practice of Billroth, 3 also proved fatal. Pinner recommended obliteration of the cyst by injection of tincture of iodine, but Schmidt stated that he had abandoned injections, as he had met with one death. Kottmann repudiated both injection and incision, and favored extirpation of the cyst, while Küster rejected extirpation and injection, and favored incision. Hence, the weight of opinion was in favor of Beck's operation, or of incision combined with packing the sac with lint.

Injections of iodine are frequently successful, but from the excessive suppuration and extensive sloughing which they sometimes set up, they are not free from danger. Thus, of 35 cases recorded by Billroth in 1877, 6 failed, 1 died, and high inflammation was induced in all; while of 106 cases collated by Schwalbe, in 1878, 22 suppurated and 5 died. With a view to obviate these risks, Morell Mackenzie, in 1872, substituted for iodine one part of the solution of the perchloride of iron to four parts of water, through which the cyst is converted into a chronic abscess. In performing the operation, the cyst is first punctured and emptied with a trocar at its most dependent part. When large, its size should be reduced, as in the case of hydrocele, by one or more preliminary punctures, but it should not be entirely evacuated, as the loss of support of its vessels is liable to be followed by hemorrhage into the sac. A drachm or two of the solution, according to the volume of the cyst, is injected with a syringe of peculiar construction, to prevent the accidental introduction of air, the canula is plugged, and, with the solution, is left in the cyst. At the expiration of seventy-two hours the plug is removed, and the contents of the sac withdrawn. If the fluid be found to be bloody or serous, a second injection should be made; but should it be purulent, which is the end desired, the canula is retained as a drain until the secretion becomes thin and limited in amount, flaxseed poultices being in the meanwhile kept upon the part. In a paper read at the recent Copenhagen Congress, and published in *Annales des Maladies de l' Oreille, du Larynx*, etc., for November, 1884, Mackenzie states that up to December, 1873, he had treated 68 cases of cystic and 19 of fibro-cystic goitre by this method. All of the purely cystic cases were cured, while two of the cases of fibrocystic tumors died. Since then he had treated about 125 additional cases, with uniform success.

The latest contribution to the surgery of cysts of the thyroid body is contained in the *Centralblatt für Chirurgie*, No. 43, of this year, from the pen of BURCKHARDT, of Stuttgart, who agrees with Kottmann in recommending excision to the exclusion of other measures. All of his 17 operations were successful. In more than one-half of the cases the cyst was larger than a goose's egg, and in six cases previous injection with iodine had failed. The sutures and drainage-tube were generally removed at the first dressing, or on

the eighth day, and complete cicatrization resulted in nineteen days, on an average.

The operation itself is not difficult of performance, nor will it be attended with more than ordinary hemorrhage, if proper precautions be observed to prevent it. The capsule of the gland having been exposed by an incision made either in the middle line or along the anterior border of the sterno-cleido-mastoid muscle, in accordance with the location of the cyst, it is laid open after previous double ligation and division of the numerous vessels which are distributed to it. Should the wall of the cyst be covered, as not infrequently occurs, especially when the sac is deeply seated, by a layer of gland tissue, which may be recognized by its peculiar red tint, this should also be opened without fear of hemorrhage, since its vascular supply has been interfered with by the compression exerted upon it by the cyst. The sac proper having in this way been exposed, it is carefully enucleated with the fingers, or curved blunt instruments, great care being taken to secure all resisting bands, which are really the vascular connections of the sac, between two catgut ligatures before they are divided with the scissors. The great secrets of success are the observance of the rule to cut nothing except between the ligatures, and the securing of proper drainage under antiseptic dressings.

In a paper published in the *Revue de Chirurgie*, No. 8, 1883, we find that Julliard, of Geneva, is also a strong advocate of excision of the sac. In support of his views, he narrates 6 cases, all of them successful, in which the cyst varied in volume from that of a billiard ball to that of a fœtal head.

From a consideration of the results of the various methods of treating cysts of the thyroid gland recorded in the preceding paragraphs, the following conclusions may be drawn: First, That when the wall of the cyst is unusually thick, or the seat of cartilaginous or calcareous deposits, or when it is constituted in part by gland tissue, excision of the sac should be resorted to; Secondly, That, under ordinary circumstances, the excitation of suppuration, by the injection of a diluted solution of perchloride of iron, followed by adequate drainage, holds forth the best prospects for a safe and radical cure; and, Thirdly, That injections of tincture of iodine should be abandoned.

SOME RECENT VIEWS AS TO ECLAMPSIA.

DELORE, in the *Archives de Tocologie* for November, asserts the probable microbian origin of eclampsia. Among the arguments which he presents to uphold this strange hypothesis, are the following: The prodromata indicate a progressive alteration of the blood—they constitute the stage of incubation of germs; as in scarlatina and typhoid fever, there are found albuminuria and nephritis in all degrees; a high temperature which increases after death, and this post-mortem hyperthermia he believes to be due to bacterial changes in the blood mass; finally, as in several affections indisputably of bacterial origin, convulsions occur at the beginning.

The theory of microbes, in the etiology of maladies has a wonderful elasticity when it can thus be stretched to include the phenomena of eclampsia; and, if these can be included, "the whole unbounded" empire of disease will soon be under microbian law, and the practice of medicine become chiefly the use of antiseptics.

FÉRÉ, in the *Archives de Neurologie*, endeavors to show a close connection between eclampsia—not only puerperal, but infantile also—and epilepsy. He states that, while ancient authors admitted eclampsia was a neurosis analogous to epilepsy or to hysteria, since the frequency of albuminuria in scarlatina and in the puerperal state has been observed, opinions have changed, so that it was no longer asked if the subject be a neuropathic predisposed to cerebro-spinal reactions, but everything was explained by a so-called specific action of altered blood upon the central nervous system. Féré's effort, then, is to show the neuropathic predisposition of the subjects of eclampsia and the little-known bonds uniting eclampsia and epilepsy; that these two disorders are not only in relation by their clinical analogies, but they ought to be by their pathogeny. The views presented by Féré are interesting and important, but larger observations are needed to confirm the truth which he believes is indicated by them.

As to the relation between epilepsy and eclampsia—we mean eclampsia as occurring in pregnancy, in labor, or in childbed—one might ask, Why should the latter be attended with such acute mortality, while the former is not fatal? And, again, one does not bleed an epileptic, while an eclamptic can be bled in almost all cases with the best results. If *cura ostendit morbum* be true, this is not an epilepsy which is cured by bleeding.

THE PENNSYLVANIA ANATOMICAL ACT.

THE medical profession in some of our States, and especially in Illinois, are taking active steps toward obtaining new Anatomy Acts. In view of this fact, and of the recent passage by the State Legislature of Pennsylvania of a new Act, it may be worth while to lay before our readers a brief sketch of the law and of its excellent working. In our issue for August 11, 1883, we published the full text of the law as proposed by the anatomists and enacted by the Legislature.

It provides a State Anatomical Board composed of the professors and demonstrators of anatomy and

of surgery of all incorporated medical and dental schools, and one representative from every such private school. This Board shall distribute to each school, in proportion to the number of students in their anatomical and surgical classes, all unclaimed and unknown bodies, which would otherwise be buried at the public expense. Each school reports to the Board, at stated times, its number of students as a basis of such distribution. In each county of the State unclaimed bodies may be delivered through the Board to any physician in the county who complies with the provisions of the Act as to filing a bond. Thus it legalizes dissection throughout the State, and affords facilities for anatomical study to those who could secure no such opportunity, except by leaving their practice and coming to Philadelphia. All bodies not so needed in each county are, at the expense of the Board, forwarded for use in the large schools, whose students come from all parts of the State.

This Act has only been in operation practically since September, 1883, yet its good results are already apparent. To put such a law in operation in the many counties in the State and in numerous institutions, has required a large amount of labor and much patience and tact. Prejudice has in some cases only slowly yielded, but gradually the operation of the law is being extended over a larger area, and, as the figures will show, it is working most satisfactorily. The voluntary Anatomical Association, which preceded the present Board, received and distributed in the year 1879–'80, 243 subjects; in 1880–'81, 222 subjects; in 1881–'82, 302 subjects; and in 1882–'83, 244 subjects. In the year ending April 1, 1884, there were received 283 subjects, but the law had then just begun to be enforced. In the first half of the present year there have been received in all 232 subjects. As the field of operation of the law is being gradually extended, it is fair to estimate that the supply for this year will reach at least a total of 400, and possibly even more. Even this number, however, is far too little for the wants of our great schools. The Board, however, are gradually putting the law in working order in counties as yet unreached, and the supply will soon be adequate to all the demands of the schools for properly educating their students.

The Pennsylvania Anatomy Act has been proved by its working to be the best law in force in this country, and we are glad to learn that the profession in Illinois will endeavor to have substantially the same law passed. We bespeak for them all the help our readers can give them. They have gone to work in the right spirit, and with a systematic effort which deserves and should command success. Such a law is the only means to provide the physician with a knowledge of this fundamental study; and is the surest means of preventing desecration of graveyards,—a crime which is so shocking to the moral sense of the entire community.

DECOMPOSITION OF MILK.

As an evidence of the degree of refinement to which the study of mycology is now being carried may be quoted some recent investigations by DR. HUEPPE, of Wiesbaden, on the decomposition of milk, which were reported at the recent Congress of German Naturalists and Physicians, and published in full in the *Deut. med. Wochenschrift*, Nov. 27. As the result of these, he has divided the organisms which are concerned into three classes, all of which are characterized by distinct and easily recognized microscopic characters. They include, 1st, those which produce acid products; 2d, those which act like rennet; and, 3d, those which produce pigment.

The spontaneous formation of lactic acid is produced by a short bacillus, which converts the sugar of milk into lactic acid and carbonic acid. A micrococcus cultivated from saliva produces lactic acid in smaller quantity, but no carbonic acid. Lactic acid together with an intensely red pigment is produced by the micrococcus prodigiosus; while the micrococcus of osteomyelitis, besides its own peculiar malignant action, produces both a yellow pigment and lactic acid. In like manner butyric acid is produced by a special bacillus, as is also the fermentation peculiar to koumys.

The bacteria acting like rennet, peptonize and dissolve the casein. Among the pigment-producing bacilli are certain green, fluorescent bacilli, as well as blue bacilli, which are the causes, respectively, of green and blue milk. The former is an earlier condition than the latter. The latter is only partial, unless the lactic acid fermentation is also present, when a deep blue succeeds to the fainter blue.

Koumys is produced by the action of the lactic acid organisms, which form lactic and carbonic acids, hydrate a part of the milk-powder, and render the alcoholic fermentation by yeast possible, and, further, by the action of the peculiar fungus, the dispora caucasica, which first dissolves the casein, and later decomposes it.

In like manner, the variously colored urines and sputa are due to different varieties of fungi.

THE INTRAUTERINE COMMUNICABILITY OF ERYSIPELAS.

KALTENBACH narrates, in the *Centralblatt für Gynäkologie* for November, a case which seems to prove that the fœtus may derive erysipelas from the mother. A pregnant woman had erysipelas in May, followed by another attack which began on the 19th of June, and she was delivered of a well-developed male child,

weighing about eight pounds and a half, on the 15th of July. The head, neck, and thorax of the child showed thick lamellæ of detached epidermis, and in a few days a similar desquamation was observed upon the buttocks. Kaltenbach states that he has never seen such a large separation of the epidermis in the new-born, and that the surface thus left was similar to that seen after desquamation in scarlet fever, or in erysipelas.

Conclusive proofs that the child had suffered from erysipelas while in the womb were wanting; for neither in the scales nor in the placenta were Professor Boström's erysipelas cocci to be found, and culture experiments were also in vain. But these negative results were attributed to the fact that the experiments were made long after the end of the disease.

Erysipelas is not a common disease in pregnancy, and when it occurs, if the attack be severe, abortion is very likely to be caused, and hence great interest attaches to this case, reported by Kaltenbach. This single observation is of course not conclusive, but it may lead to the reporting of similar cases.

Charpentier, referring to erysipelas in pregnancy, states that the disease is less grave than variola, and should be, in regard of gravity, classed with rubeola. The sole case falling under his own observation was that of a woman taken about the fourth month of pregnancy with the disease, and who had until the end of the pregnancy, which terminated in the birth of a living child, a succession of attacks of facial erysipelas, recurring from month to month, which were remarkable for the slight intensity of the febrile phenomena, although the eruption was well marked. That the fœtus escaped the disease, although some six attacks occurred to the mother, is an argument against the correctness of Kaltenbach's view.

A USEFUL HINT TO AUTHORS AND PUBLISHERS.

WE purchased, the other day, a copy of that excellent book published by Henry Holt & Co., of Boston—*The Human Body*, by H. Newell Martin, of Johns Hopkins University. In it we find so excellent an idea that we call special attention to it. From the librarian's point of view, it is as useful as it is novel.

On a fly-leaf in front of the title-page are printed "slips for librarians to paste on catalogue cards." These are four in number, under the several captions—"Martin, H. Newell," "Human Body," "Anatomy," and "Physiology"—with the full title, etc. The librarian has only to cut these out and paste them on four cards, instead of the laborious writing of the title four times. Moreover, it is a great gain in legibility.

We recommend the idea to authors and publishers as well worthy of imitation.

SOCIETY PROCEEDINGS.

NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 11, 1884.

THE PRESIDENT, ROBERT F. WEIR, M.D., IN THE CHAIR.

DR. GERSTER presented a case of

ANEURISM OF THE RIGHT SUBCLAVIAN ARTERY,

in a patient with the following history:

Aug. B., fifty-one years old, a cigarmaker by trade, never had syphilis, and no vestiges of the disease being visible, presented a large bony frame covered by wasted flabby muscles, and a pale, sallow skin. He alleged to have noticed increasing very acute pain along his right arm since the summer of 1883, accompanied by wasting of the muscles and a peculiar bluish discoloration of the skin of the arm and hand. Since the fall the terminal phalanges on the right hand became shovel-shaped, the nails like claws, and his general condition very mnch impaired by constant pain, formication in the hand, and lately increasing dyspnœa. Shortly before New Year's, 1884, Dr. John Schmidt noticed at the German Dispensary a pulsating tumor behind and to the right of the sternoclavicular joint of the right side, and diagnosticated an aneurism of the right subclavian artery. I confirmed the diagnosis, but thought that the location of the tumor, the pulsatile elevation of the sternoclavicular joint, a corresponding dulness, and the dyspnœa warranted the assumption that the anonyma at its bifurcation was also concerned in the lesion. The characteristic bruit was present, the carotid and radial pulses were normal, and synchronous with the heart's action. The inferior cervical triangle of the right side presented not a depression, but a distinct elevation above the level of the clavicle and sterno-mastoid muscle. The main swelling and resistance being probably situated in the angle of the clavicle and the sterno-mastoid muscle, direct pressure on the tumor was not tolerated on account of the intense pain, but reduced the swelling and pulsation to a great extent.

On January 16, 1884, I deligated the common carotid and the subclavian, or, according to English nomenclature, the axillary artery, the latter being tied in Hohrenheim's triangle, below the clavicle. The ligatures used were juniper catgut. The incisions were sewed up—not drained. Immediately after the ligatures were applied, the radial pulse and that of the carotid disappeared; but the pulsation of the tumor became more violent than before, when the ligature on the carotid was tightened. Nothing abnormal was observed regarding the pupils, the heart's action, or respiration.

For a considerable period of time no appreciable difference in the conformity of the pulsating swelling was observed; on the contrary, the shooting pains and formication along the branches of the brachial plexus seemed to increase. The wounds healed correctly under a single dressing. About four weeks after the operation it first became apparent that the tumor had decreased in size. Simultaneously the pains became more tolerable. In March and April thirty hypodermic injections of Bonjean's ergotine were made in the abnominal region, and seemed to hasten the shrinking of the tumor, which now

became very manifest. By May the cyanosis, hyperidrosis, glossy skin, and formication, as well as the neuralgic symptoms, had so much abated that the patient could sleep without opiates, and had gained over ten pounds in weight. The atrophy of the muscles of the arm and forearm had also improved materially under massage and active exercise; and now the patient, who seemed to be at death's door, may be said to be fairly and sufficiently comfortable to enjoy life, and to attend to his avocations. The abnormal pulsation and bruit have entirely disappeared, and only a well-perceptible fulness and resistance seen and felt in the right supraclavicular fossa as compared with the other side; short, mild, and rare attacks of shooting pains along the arm and up the nape of the neck; finally, the peculiar shape of the terminal phalanges of the hand and nails of the right hand have unavoidably remained behind. It seems that the subclavian portion of the aneurism is filled up with a solid clot, the radial pulse being absent to this day.

DR. SANDS thought it might be a question whether the aneurismal sac was completely obliterated. It was evidently firm, but pulsation was quite marked.

DR. GERSTER said that perhaps he might be allowed to correct himself in so far as he said in his written history of the case, that he believed a solid clot filled that portion of the aneurism which belongs to the subclavian. The radial pulse had appeared only very lately.

DR. L. A. STIMSON referred to a case which he reported four years ago, in which he ligated simultaneously the carotid and subclavian for aneurism of the innominate artery. There remained a distinct pulsation in the sac above the clavicle. The patient died twenty-one months subsequently of acute phthisis, and at the autopsy the aneurismal sac was found completely filled by a firm clot, except for a very narrow slip-shaped opening, through which blood passed from the aorta to the branches of the thyroid axis.

Of course, it could not be said positively that the condition at the autopsy was the same as that which existed at the time the patient was presented to the Society. But there was up to the time of the patient's death pulsation in the sac the same as when he was presented to the Society. In his mind there was no question but that the pulsation was a communicated one; and in Dr. Gerster's case he should not regard the pulsation as proof positive that the sac was not occupied by a clot.

OSTEOPLASTIC EXCISION OF THE ELBOW-JOINT.

DR. L. A. STIMSON presented a patient upon whom he had performed excision of the elbow-joint. He thought it worthy of presentation because, first, the operation was a modification of one that had recently been introduced; and, second, because of the complete restoration of the form, and partial restoration of all the functions, of the joint.

The patient was a boy sixteen years of age, who, sixteen months before coming under observation, received a blow on the outer side of the left elbow, which was followed by swelling, heat, tenderness, and the formation of many sinuses in the arm and forearm. When Dr. Stimson first saw the patient the limb was swollen, the joint was painful. Though capable of some motion, there was lateral mobility, with grating. The excision was performed on the 17th of May last. An incision according to Ollier's method was made, extending along the outer aspect of the lower end of the arm, and then diagonally across to the olecranon and along its outer edge. From this, at the lower end, a transverse incision was made across the ulna. The joint was opened freely, and the olecranon divided obliquely backwards at its thinnest part. The triceps and the adherent posterior part of the olecranon were then reflected to the inner side and the joint freely exposed, the inner condyle denuded through a small incision over the epitrochlea, and then the humerus divided by a transverse cut through the epicondyles. The surface of the olecranon was freely scraped, and it was necessary to remove almost the entire coronoid process.

As this scraping had greatly enlarged the sigmoid cavity, he removed a segment of bone, one-fourth of an inch in thickness, adjoining the incision, through the olecranon, and thus shortened this cavity. Then, because of induration of the soft parts covering the front of the joint, he removed another slice, one-fourth of an inch in thickness, from the humerus. The sinuses were then freely scraped, and the limb was dressed in the usual manner. The olecranon was reunited by silver sutures. The course of the case was uneventful. The sutures were removed about two months after the operation.

The patient now has very free motion in the joint, and good restoration of the form of the limb. Extension is particularly strong; flexion is weaker than extension. There remains an opening on the inner side of the arm, but it does not communicate with the bone. The patient can flex and extend the elbow actively.

The bone was divided with an instrument brought to this country from England last spring, and consisting of a combination of forceps and chisel-shaped saw, called an exsector. It is like an ordinary forceps with the claws at right angles to the handles, and on the side of the joint there is a small, flat shell on a pivot, which holds the saw, allows it to be worked from side to side, and thus cut its way downwards along the sides of the claws. The instrument in his hands had proved very satisfactory.

DR. GERSTER could not share with Dr. Stimson in his good opinion concerning the instrument mentioned. He had used it five or six times, and had seen it used by other surgeons, and he must say that it had two disadvantages: First. It is a complicated instrument which easily gets out of order, and is very difficult to clean. Second. The leverage of the claws which take hold of the bone is disproportionally great, and he had seen the epiphysis of an infantile bone completely crushed by it.

DR. STIMSON had not encountered any of the objections which Dr. Gerster had mentioned with reference to the exsector. He had, however, found it necessary to round the corners of the chisel in order to make it work more easily. The excessive amount of force which the instrument was capable of exerting, Dr. Stimson thought, was within the control of the surgeon who applied it.

DR. W. S. HALSTED presented cases of

PARTIAL RESECTION OF THE ELBOW AND SHOULDER FOR TUBERCULOSIS, AND OF THE ANKLE FOR TRAUMATISM.

Case I.—Elbow; I. E. D., male, æt. 36. Patient believes that a brother died of consumption. Family history otherwise good. About two years ago, pain, spontaneous and insidious, developed in right elbow; until July, 1884, patient's suffering has been inconsiderable. His sleep was little disturbed, and moderate movements of the affected joint did not cause pain. Examination on admission, July 22, 1884: consolidation at apices of both lungs; urine, sp. gr. 1028, and contains oxalate of lime. Spindle-shaped enlargement of right elbow-joint. Fluctuating swellings to the outer side and back of both condyles of humerus. Flexion to an angle less than a right one, painful. Inner swelling incised and about one ounce of cheesy pus evacuated, and, September 3d, patient's elbow has for several weeks annoyed him greatly. Injections of iodoform ointment, through fistulous tract into joint, contributed at first to his comfort. Anodynes, even in large doses, give little relief. There is much redness about the joint, and the slightest motion causes great pain.

Operation: 9 A.M.; ether; Esmarch's bandage, and as strict antiseptic precautions as practicable.

Incisions: first, longitudinal, eight inches in length, parallel to and just inside of inner border of olecranon; second, transverse, at right angles to first incision, outwards to plane of radius, opening joint and dividing triceps muscle close to its insertion into the upper border of olecranon process; third, short longitudinal at right angles to second incision, and parallel to outer border of olecranon, to neck of radius.

Operator preferred dividing triceps to sawing through olecranon, as proposed and practised by Bruns, Mosetig Moorhof, and others, and by Dr. Stimson in the case just presented by him, because simpler in the first act, viz., opening the joint, and in the subsequent acts, should it prove necessary, as it almost invariably must, to remove the articular surface of the olecranon. The joint, then, being still more thoroughly exposed by liberating the sides of the olecranon from the triceps and anconeus attachments, all the articular surfaces were found to be more or less involved in the disease, which was distinctly tuberculous with, fortunately, sclerotic confines. The articular surfaces of the humerus, head of radius, and of both sigmoid cavities were sawn off; also the upper surface of the olecranon. Thus a rectangular replaced the sigmoid cavity somewhat as figured in Linhart's *Operationslehre*. The capsule and articular ligament were completely dissected out, and the walls of the sinus scraped with a Volkmann's spoon. The end of the humerus was sewed with catgut into the step made in the olecranon, and the space necessarily left between the humerus and radius was obliterated by turning into it the divided triceps and anconeus muscles which were retained by several sutures.

Other small dead spaces were obliterated by quill sutures. Wound closed by furrier's suture, and three short drainage-tubes introduced.

The dressing was applied previous to the removal of Esmarch's elastic bandage, and the limb, flexed to about forty-five degrees, was preserved from constriction by the introduction, in the dressing, of narrow strips of wood to distribute the pressure made by the tightly applied bandage. The arm was, of course, maintained elevated for about thirty-six hours.

Sept. 6.—Dressing changed; edges perfectly united; no signs of inflammation.

15th.—Redressed; drains apparently almost absorbed. No pus. Rectangular splint applied.

26th. — Small subcutaneous abscess in cubitus opened, apparently has no connection with the joint. The patient, as presented, seemed to have a perfectly healed joint. There still remained in the cubitus the mouth of a subcutaneous fistula, of about half an inch in length, which did not, apparently, lead toward bone.

Although but six weeks after the operation, the patient could flex and extend the elbow moderately and without pain. Dr. Halsted advocated partial as opposed to so-called typical resections of the elbow-joint for tuberculosis.

Case II.—Shoulder; I. H., male, æt. 15. No tuberculous heredity ascertained. All members of immediate family alive and healthy. About middle of April, 1884, wrenched left arm while lifting down a coal-scuttle. Felt pain immediately in left shoulder-joint severe enough to prevent sleep for three nights; on the fourth day pain had subsided, except on motion. A few days later, applied at Roosevelt Hospital Out-patient Department for relief. Examination: Muscles about joint much atrophied. Head of humerus affected; appears smaller than on sound side. Joint not thickened at any part; fixed by muscular action. Passive motion, and palpation of joint painful. No points of special tenderness. Treatment: Plaster-of-Paris splint.

Aug. 20.—The splint which was applied in April removed to-day. No pain whatever since its application. Fluctuating tumor, about size of pigeon's egg, at back of joint under deltoid muscle. Skin over it, normal.

26th.—About one drachm of flocculent pus withdrawn by Pravaz's syringe from abscess referred to in last note, and a few drachms of iodoform ointment (iodoform one part, almond oil two parts) injected into abscess cavity. Examination of pus by Dr. R. I. Hall reveals, from eight cover-glasses, five tubercle bacilli.

27th.—Patient is confident that he was benefited by the iodoform injections, and unwillingly allows repetition of the aspiration and injection of the cavity, which had more than attained its former size.

Sept. 14.—Condition essentially unaltered.

16th.—Arthrotomy; posterior incision through abscess leads directly into joint which is distended with pus. The much diseased head of humerus sawn off at surgical neck; glenoid cavity and capsule also extensively involved in the tuberculous process and scraped with sharp spoon. Furrier's suture; short rubber drain at lower angle of wound.

30th.—Two weeks after operation, original dressing removed. Wound healed, without pus to drainage-tube. Tube removed.

Oct. 10.—Second dressing.

Nov. 1.—Wound entirely healed. Free passive motion does not cause pain; active movements inconsiderable. Electricity to deltoid.

On presenting the patient, whom he had not seen for

one week, Dr. Halsted discovered a small fistulous tract at the lower angle of the wound.

The interesting features in the case were its traumatic origin, immediate atrophy of deltoid muscle, the unsuccessful iodoform injections, the rapid healing of the wound, and the early partial restoration of function.

Case III.—Ankle; C. L., æt. 27; admitted to Roosevelt Hospital October 17, 1883. Just before admission, had been thrown from a horse, and, falling on his feet, his right foot turned under him.

Examination: Tibia and fibula protrude from an extensive wound on the outer side of the ankle, the foot being strongly supinated. Both malleoli are broken off and adherent to dislocated foot. Patient etherized; malleoli removed, and two inches or more of lower ends of splintered upper fragments of tibia and fibula. Furrier's suture. Rubber drainage-tube through joint.

Oct. 30.—Wound dressed for first time. Complete union along lines of suture.

Nov. 7.—Second dressing; superficial ulcers where drainage-tube had been.

Dec. 14.—Patient walks with crutches. On presentation, walks easily with lateral brace. Can flex and extend ankle quite as much as, if not more than, on sound side, notwithstanding the shortened leg bones.

Corrosive sublimate solution, 1 to 1000, was used as irrigation fluid and iodoformized gauze as dressing in the three cases. The wounds healed in all primarily.

DR. JOSEPH C. HUTCHISON then read a paper, entitled

A CASE OF EXTRACAPSULAR FRACTURE OF THE NECK OF THE THIGH-BONE.

On the 31st of August, 1883, two gentlemen, one a medical man, 56 years old, weighing 204 pounds, and enjoying robust health, drove in a high-top buggy from Lake Luzerne to Lake George in order to make a professional visit. The horse seemed to be perfectly gentle, and required a good deal of urging to make him accomplish the trip in a reasonable time. The "turn-out" was furnished by a livery stable.

They drove up to the piazza of the Fort George Hotel, stopped, and, as they were preparing to get out, the horse suddenly started to run, and, making a short turn, the wheels became locked, the buggy was upset, and the occupants were thrown violently to the ground.

A medical gentleman who saw the accident hastened to assist his professional brother to get out of the way of the horse, which, after running some distance, turned and came back over the same road with the fragments of the wagon dangling at his heels, apparently with the purpose of finishing his work of destruction. The doctor had walked, with a little assistance, five or six steps to get out of the way of the running horse.

He suffered deep-seated and severe pain in the right trochanter major, which received the force of the blow, and at once concluded that he had an impacted extracapsular fracture of the thigh-bone. This opinion was based upon the fact that the pain in the trochanteric region was excessive, and it seemed impossible that so heavy a man, thrown violently to the ground from such a height and striking upon the the trochanter, could have escaped this fracture; and he inferred that the fragments were impacted because he had been able to take a few steps after the injury. So sure was he of his diagnosis that he requested the surgeon who was on the spot and assisted him in getting out of the way of the horse not to manipulate the limb for fear of disturbing the impaction. He did not lose consciousness, nor did he suffer from shock in the slightest degree.

The other gentleman got up immediately without assistance, but was greatly shocked, and it was subsequently found that he had a broken rib.

Soon after the doctor was put to bed he was carefully examined by Drs. S. W. H. Hall and G. E. Munroe, who were summering at the hotel, and also by Prof. Frank H. Hamilton, who was staying at a neighboring hotel. Two of the surgeons found from one-half to two-thirds of an inch shortening of the limb; the other, after repeated examinations, satisfied himself that there was no shortening. The was no eversion of the limb, and the patient was able to invert the foot to a moderate degree; there was considerable pain in the right groin and also in the trochanter. The pain in the trochanter was relieved instead of being increased by pressure. The skin was contused directly over the outer side of the trochanter, showing that the fracturing force was applied transversely to the axis of the neck of the femur. The absence of bruises at any other part of the surface proved that the trochanter had received the full force of the fall. No manipulation was made for the purpose of detecting crepitus and settling definitely the question of fracture. A positive diagnosis was not expressed at this time by the attending surgeons.

During the night the patient suffered greatly with pain about the upper part of the femur, which was aggravated by muscular spasms whenever he fell asleep. He was relieved, in a great measure, by lying upon the right trochanter; the pressure of the bed against it acting as a splint. He could not raise the heel from the bed, but was able to flex the thigh slightly upon the pelvis by bending the knee-joint.

On the following morning Dr. Hamilton observed depression of the right trochanter and an unnatural fulness in the inguinal region, which, with the development of muscular twitchings during the night about the seat of the injury, in addition to the signs previously mentioned, convinced him that there was an impacted extracapsular fracture. Dr. Hamilton stated that he regarded muscular spasm in this region after a recent injury as generally pathognomonic of fracture of the cervix femoris—a statement which the writer does not remember to have seen mentioned by any author. The patient was advised to get to his home, two hundred miles distant, as soon as possible. No apparatus was applied, because it would have increased the inconvenience of transportation, and the surgical knowledge of the patient would induce him to keep the limb quiet and in the best position to prevent separation of the fragments. Owing to the crowded state of the cars at that season of the year, great difficulty was experienced in securing proper transportation. Finally, by the unwearied exertions of a friend, a private car was obtained from a distant city, and the patient was conveyed to it from the hotel very comfortably on an improvised stretcher. The transportation from the hotel to the city was under the direction chiefly of Dr. J. H. Sterling, of Brooklyn. The stretcher was borne by six men, two others accompanying it as a relief. The patient turned himself upon his right side, so that the trochanter major was well pressed upon.

The transportation to the car was comfortably made, and he was placed upon a spring mattress upon the floor. Soon after leaving Lake George, the car, which was the last on the train, bumped violently against the one in front, producing severe pain at the seat of the fracture. A second bump took place with a like result, and then the superintendent had the car well manned with a hand-brake, which prevented any further concussion.

The patient slept moderately well during the remainder of the night, and reached the Forty-second Street depot at seven o'clock the following morning, when he was met by an ambulance, which had been kindly furnished by the Brooklyn Health Department, and was conveyed to his residence. He was driven through New York and Brooklyn at a moderate pace, and expressed great satisfaction with his comfortable ambulance experience. He was strongly impressed with the superiority of this method of carrying the sick and injured over those formerly used. Before leaving the depot, a long splint was applied to the outer side of the injured limb; but the patient, finding it irksome, removed it, and again turned over on his trochanter. On reaching home, he was placed on Hooper's invalid bed, which he had purchased two years before in London; not with the expectation, however, that he would be the first to use it. He was then allowed to rest undisturbed until the afternoon, when Buck's dressing was applied by Dr. A. R. Paine, assisted by Dr. Rand. A ten-pound weight was used; not for extension, but to steady the limb and to relieve muscular spasm. This was soon reduced to seven pounds, with the addition of another pound at night. Lateral pressure was then made against the trochanter by means of a heavy bag of sand. This was suggested by the relief afforded the patient by lying on the trochanter before the leg was dressed. The pressure was kept up night and day for thirty-five days, and the patient was on the alert to have it closely applied because it gave him great relief. During that night, and for three succeeding nights, the muscular twitchings returned whenever he fell asleep, which gave him great pain at the seat of injury, lasting for half an hour. These spasms of pain were alleviated somewhat by fifteen drops of Magendie's solution of morphine given at bedtime.

On the third day after reaching home, five days after the accident, our patient requested Dr. W. S. Halsted to send him his modification of Volkmann's splint, which he intended to have applied if loosening of the fragments and eversion of the limb should take place. He believed that this apparatus would be more comfortable, if not more efficient, than the long external splint, in controlling eversion.

Dr. Halsted kindly brought the apparatus himself. and the patient and surgeon in charge acceded to his suggestion to apply it at once. As there was no separation or loosening of the fragments, and therefore no eversion of the foot, the only advantage which Halsted's splint had in this case over Buck's extension alone was that it enabled him to move more easily up and down in bed. Towards the end of the third week, a marked painless swelling, unmistakably callus, was noticed in the groin, just outside the femoral vessels, which disappeared in due time. On the fortieth day the dressings were removed; on the forty-second day the patient got out of bed, and, by the aid of a chair, crossed the room to a lounge; on the following day he moved about on crutches; and on the eighty-fourth day he laid aside his cane. During the whole period of his confinement to bed, all his functions were regularly and normally performed, and he felt perfectly well after the pains from the muscular twitchings, during the first week, had subsided. Eleven months after the injury there is nothing to indicate that the patient has had a fracture of the thigh, except the diminished prominence of the trochanter major, flattening of the corresponding side of the nates, and an unnatural fulness in the inguinal region; there is no limp; the motions of the joint are perfect; there are no osteophytes; and he exercises on horseback with as much pleasure and comfort as formerly.

It will be observed in the history of this case that two of the most important signs of fracture of the neck of the femur, whether impacted or not, were absent, viz., pain on pressure over the trochanter and eversion of the limb. Pressure against the trochanter major, instead of aggravating the pain, gave great relief, and on that account was constantly kept up; first by lying upon the trochanter, and after the apparatus was applied by means of a large sandbag. There was absolutely no eversion; the position of the foot was normal; and the right foot can now be inverted and everted as far as the left.

Outward rotation of the limb in impacted, as well as other fractures of the cervix femoris, is the rule, but exceptional cases are recorded in which the limb was inverted, or the position of the foot was normal, turned neither in nor out. The position depends upon the direction of the fracturing force.

This fracture is produced, in a great majority of cases, by falling forwards and on the side, striking the front and lateral aspects of the trochanter. The forces applied in this direction would inevitably produce posterior impaction and eversion as a consequence. But if the force is received upon the outer and posterior aspect of the trochanter, the anterior wall will be impacted, and we shall have inversion of the limb, and, when the fracturing force is applied directly upon the outer surface of the trochanter in the direction of the axis of the neck, as in the case here reported, the whole base of the cervix is implanted into the trochanteric portion of the femur, and the limb will retain its natural position.

When we remember that inequality in the length of the lower extremities is often a normal condition, which may have existed in this case; that there was no pain on pressure over the trochanter; that the foot rested directly upon the heel; and that the recovery was so rapid and complete, the question may naturally arise, Was this a case of fracture, or was it an injury which did not involve the integrity of the bone?

Every experienced surgeon is aware of the difficulties sometimes attending the diagnosis of fracture of the neck of the femur, especially when the upper fragment is firmly implanted into the cancellated tissues of the lower. A majority of the symptoms of fracture may be present in cases in which the neck of the femur is uninjured; and, on the other hand, fracture may be unaccompanied at first by the more important of the usual diagnostic signs. In cases of violent contusion of the

periarticular muscles of the hip, all the component parts of the joint having received a severe shock, the result of a fall upon the trochanter, the symptoms at first are almost identical with fracture. In either case there may be eversion of the foot, shortening of the limb, which existed prior to the injury, an absence of crepitus, and an inability to raise the extended limb from the bed by a voluntary effort. In such a case how are we enabled to ascertain the real nature of the injury? This can generally be done by observing the relation which the trochanter major bears to the anterior superior iliac spine. When the relative position is the same on each side, it usually indicates that there has been no other injury than contusion; but when it is altered in a joint previously healthy it denotes the presence of fracture.

A change in the normal relation of the two processes does not, however, always indicate the existence of fracture. A change in the position of the trochanter major, with reference to the iliac spine, may have been produced by chronic rheumatism of the hip-joint. In such a case the bearings of the trochanter with respect to the iliac spine will not serve as a diagnostic mark between a contusion of the hip and an impacted fracture of the neck of the femur. The previous history of the case will, however, assist in determining the nature of the lesion. In investigating these injuries, however, we should not form our opinions from any particular symptom, but all the symptoms which the case presents should be considered in order to arrive at a correct diagnosis. In the case under consideration the pathognomonic symptoms of fracture were, first, depression of the trochanter major on the injured side. This process was, according to the measurement of Dr. Halsted on the fifth day after the injury, three-quarters of an inch nearer the iliac spine on the right than on the left side. Second. The spasms or twitchings in the muscles surrounding the joint during sleep and continuing five days. Third. The deposit of callus towards the end of the third week in the groin, on the outer side of the femoral vessels, and just below Poupart's ligament.

An interesting incident in the case was the variation in measurements by the three surgeons who first saw the patient—all men of large experience in the treatment of fractures. This is, I believe, not an uncommon experience. We cannot always be sure that we have measured from exactly corresponding points on the anterior superior spinous process of the ilia.

Before getting out of bed measurements were repeated by Dr. E. R. Squibb and Dr. A. R. Paine with great care. They found from a quarter to a third of an inch shortening. On June 14th the patient was measured by Prof. Frank Hamilton, who found only one-sixth of an inch shortening. He remarked that he had never before seen so good a result after such an injury. The small amount of shortening indicated that the impaction was not deep, and yet it was enough, with intelligent care on the part of the patient, to prevent separation of the ends of the fragments. The diagnosis of fracture was sufficiently clear in this case without manipulation. But, had there been a reasonable doubt of the nature of the injury, violent manipulations would have been manifestly improper. The utmost caution was observed in examining the limb.

In any case of suspected impacted fracture of the cervix femoris the discreet surgeon will prefer to treat the case as one of fracture, rather than incur the risk of damaging his patient by instituting such an examination as is necessary to produce crepitus. This rule should be observed even when the bone is not impacted in the best position. It is better that malposition of the limb should not be corrected than that impaction should be broken up by unwarrantable manipulation and the union of the fragments thereby endangered. The most important feature in the treatment of such cases is, therefore, to maintain the impaction. This can be best accomplished by keeping the patient at rest; by avoiding undue manipulations; by moderate extension in the straight position to steady the limb; and by lateral pressure over the trochanter by means of a sandbag, or a long external splint, or by the use of Volkmann's splint.

Violent extension would disengage and displace the impacted fragments, and make non-union almost inevitable. If, for any reason, it is necessary or desirable for the patient to go out before firm union of the fracture has taken place, this may be done with safety at the end of the fifth week by applying one of Johnson's felt splints, or some similar appliance, enveloping the body to midway between the hip and axilla, and the thigh and leg to midway between the knee and ankle. The felt is made pliable by holding it before a fire, or immersing it in hot water, or, still better, by covering it with a wet cloth and softening it by a hot smoothing iron. It is then applied over a tight-fitting pair of drawers and rapidly covered with a bandage. The splint adapts itself to all the inequalities of the surface, and, if well applied, does not make undue pressure at any point.

Our patient amused himself by applying this splint to the sound limb while in bed, and found that it made the joints absolutely immovable. The objection suggested to its use is the danger of disturbing the fragments during its application. It is much lighter than plaster-of-Paris bandages, can be applied with more facility, and with less danger of deranging the fragments.

The rapid and perfect recovery was an interesting feature in this case, and was duly appreciated by the patient. He knew that a more perfect result would be obtained by establishing motion in the joint as speedily as practicable. He had never permitted a patient to get out of bed so soon, nor would he do so now, notwithstanding his own favorable experience, unless the patient were a cautious surgeon and fully appreciated all the circumstances of the case.

DR. FRANK H. HAMILTON was invited by the President to open the discussion on Dr. Hutchison's paper, and said: I consider this paper of very great interest not only in its simple narrative of the case, but in the valuable suggestions which it contains, and the more so because the author of the paper is a surgeon of distinction and experience, and therefore relates more intelligently his own personal experiences than could have been related by a second person. For these reasons I hope the author will not withhold the name of the patient who received the injury.

As to whether or not this was originally a case of fracture, I assume that it was for one or two other reasons than those stated by Dr. Hutchison. I am in the habit of assuming, when a man of the age and weight of the

patient falls violently upon the trochanter major that he has almost certainly received a fracture of the neck of the femur, probably extracapsular. In deciding in the case under observation as to whether it was a fracture or not, this was a very important factor in the diagnosis.

A second reason was, and of still greater importance perhaps, that there was a manifest depression of the trochanter major, that the limb was a little shortened, one-fourth of an inch perhaps, subsequently one-sixth of an inch, I might explain upon the supposition that this was normal. On the other hand, it might be that the shortening was actually greater than was represented by the measurements because the injured limb was perhaps normally longer than the opposite limb. But that there was shortening, all who saw the patient have asserted.

With regard to the muscular spasms of pain, I do not say that they are absolutely diagnostic of an extracapsular fracture of the femur, but while they are often present in fractures of the shaft, they are almost universally present in fracture of the neck, especially if extracapsular. I have explained this on the supposition that the muscles and nerves in the vicinity of the fracture have been injured somewhat. The fulness in Scarpa's region which occurred later, and which the doctor recognized, would at least lead us to suspect fracture.

All the circumstances point so distinctly to extracapsular fracture of the neck of the femur that I do not think we can entertain a doubt of its occurrence, but the greatest doubt is thrown upon the case by the remarkable result; that is, there is no eversion, no osteophytes are apparent, and the shortening is very slight.

DR. W. S. HALSTED said that when he examined the patient referred to by the author of the paper, he made out from five-eighths to three-quarters of an inch shortening, not only by measuring from the anterior superior spine of the ilium to the external malleolus, but also along Bryant's line. It seemed to him to be sufficiently easy to tell whether the shortening was due to fracture of the neck or not by measuring from the top of the trochanter to the malleolus on both sides; and if the shortening along Bryant's line corresponded to the difference in measurements made from the anterior superior spines of the iliæ to the malleoli, it was fair to suppose that fracture existed.

He also noticed that the affected side was flattened extero-internally, and that there was an abnormal fulness behind the great trochanter, which strengthened his belief that a fracture existed.

DR. L. A. STIMSON thought the two opposing facts mentioned by Dr. Hamilton did not seriously affect his diagnosis. There were many specimens showing that repair had taken place without the formation of osteophytes; and as to eversion or limitation of inversion, that was a symptom dependent upon mechanical conditions which might or might not present—for example, impaction with outward rotation of the shaft upon the neck. If the impaction took place, as in Dr. Hutchison's case, without such rotation, the range of eversion and inversion would not be modified.

The occasional great difficulty of reaching a diagnosis was admitted by all. In a case recently under his own care, a fall upon the trochanter while walking, the limb was slightly inverted, and shortened half an inch, and the trochanter one-third of an inch further from the median line; no pain or pressure in front of, or behind, or upon the trochanter; inability to raise the head. Several surgeons saw the case, but declined to make a diagnosis. The shortening increased during the next week to one inch, and Buck's extension was applied, and in due time the patient left the hospital, walking without a limp, but with three-quarters of an inch shortening.

In another case, sent to Bellevue from another hospital with the diagnosis of fracture of the neck of the femur, there was inability to walk or raise the heel from the bed, and sharp pain on pressure behind the trochanter; doubtful shortening of one-quarter inch, no fulness of Scarpa's space, no pain when the limb was forcibly pressed against or pulled away from the body. The patient was left without any dressing, and in two weeks was able to walk easily with only a slight limp. He was more than fifty years old.

DR. C. K. BRIDDON saw, some years ago, a case similar to the one related by the author of the paper. The patient was on a pleasure trip, more than a hundred miles distant from his home, when he was thrown violently, his hip coming in contact with the ground. He was transported on an extemporized stretcher to a baggage car to his home, where Dr. Briddon saw him in consultation with his family physician. The limb was disabled, he complained of a good deal of pain, could not raise his heel from the bed, there was slight eversion, the movement of inversion was limited, there was about half an inch shortening, gentle rotation of the thigh elicited no crepitus, and when the trochanter was grasped during such movement it was manifest that it described the arc of a lesser circle than on the opposite side; the diagnosis was impacted fracture of the neck of the thigh-bone.

Rotation of the femur revealed one symptom which Dr. Briddon had always regarded as characteristic of the lesion. In an *unimpacted* fracture, when the trochanter is grasped during rotation, it will be felt that it is rotated through the axis of the shaft; when the fracture is *impacted*, the trochanter moves through an arc of a circle of which the head of the bone is the centre, and the excursion made by the trochanter will depend upon the depth of the impaction. Another symptom referred to in the case reported, was "fulness in the upper part of Scarpa's space." This could be sometimes felt in lean patients as a more or less bony prominence in the region of the neck, and, with the symptom of eversion, depended upon the manner of impaction, which was accounted for by anatomical considerations brought prominently before the profession by Prof. H. J. Bigelow in his essay on *The Hip*. From the examination of a number of museum specimens, Dr. Bigelow had concluded that the posterior portion of the neck was always driven in, and that the anterior portion was bent at an angle prominent in front. To ascertain the cause of this, sections of the sound bone were made, and it was found that near the junction of the neck with the head of the bone, the anterior and posterior walls were of nearly equal thickness; but that as the lower surface of the neck was approached, the anterior wall becomes of great thickness and strength, while the posterior remains thin, especially at its insertion beneath the posterior intertrochanteric ridge, where it is thin as paper, hence it is that the posterior portion of the neck is driven

into the cancellated structure of the trochanter, causing the prominence in front and the slight external rotation, and the other signs already alluded to.

Dr. Briddon stated that he had at the present time a patient under his care in the Presbyterian Hospital, in whom all these signs were made out by the most gentle manipulations, and without disturbing the relations of the parts, and he considered it as most important to avoid such handling as would be likely to break up any existing impaction,

DR. A. C. POST said that the case related by the author of the paper did not seem to accord with the opinion of Robert Smith, of Dublin, who states that in extra-capsular fracture the initial force which occasions the fracture always causes impaction; and if more force than that which causes the impaction is applied, it splits the bone through the trochanters, and the impaction is relieved.

The degree of violence in Dr. Hutchison's case seemed to be sufficient to relieve impaction by splitting the bone at the junction of the trochanters with the shaft, and in this respect the case was exceptional; and the absence of splitting the shaft of the bone would explain the absence of osteophytes.

Dr. Post further remarked that the ability to walk was not proof positive against fracture. Not long ago he saw a case of intracapsular fracture of the neck of the femur in which there was doubt with regard to the existence of fracture. The patient after a few days did walk, and there was subsequently displacement which left no doubt with regard to the existence of the fracture. Such instances, he thought, were not very rare in which, the parts being held together firmly, the patient may walk, and we may assume that in such cases the parts may unite without further separation.

DR. L. M. YALE referred to a marked case of this character which he saw eighteen years ago, and in which the patient fell, receiving his injury, walked a distance of one hundred feet, entered the wards of the hospital, and went to bed. It was a doubtful case of the kind; but as the symptoms were those of probable fracture, he was sent to the Charity Hospital, where he subsequently died of an intercurrent disease. The autopsy revealed impacted fracture of the neck of the femur.

DR. L. A. STIMSON referred to a case occurring in a patient sixty-three years of age, who received an injury of the hip, walked down one staircase, along the hall, down the next staircase, and then was unable to walk, and was brought in this condition to the hospital. The patient died three weeks subsequently of erysipelas, and at the autopsy Dr. Thomson found a pure intra-capsular fracture of the neck of the femur.

DR. SANDS said that Dr. Hutchison's case afforded a striking illustration of the difficulties experienced in determining the comparative length of the two limbs according to our customary modes of examination. It seemed that, of the several surgeons who examined the limb, no two reached the same conclusion, and that there was so great difference of opinion as to make the shortening in one instance one-sixth of an inch, and another from one-half to three-quarters of an inch, both surgeons presumably measuring between the same points. Of course, it would not be fair to assume that the length of the two limbs varied at the times they were measured, and the discrepancy arises from the difficulty in ascertaining what are called bony points. Such difficulty makes untrustworthy the reports which are published of the results of treatment; for similar inaccuracies must occur in measuring the limbs after a fracture has consolidated. In very many cases, it may be easy to fix upon the bony points for measurement; but in persons who are fat, it may be difficult or impossible to recognize them. Dr. Sands had sometimes experienced the same difficulty in obtaining definite results with Bryant's test, and believed it to be untrustworthy when applied to those in whom adipose tissue is abundant. The difficulty consists in recognizing the bony points, namely, the anterior superior spinous process of the ilium and the tip of the great trochanter. Dr. Sands thought that in cases of fracture the old-fashioned method of bringing the feet together—avoiding any obliquity of the pelvis—and then comparing the two internal malleoli, would often give results quite as correct as those obtained by methods which we are accustomed to regard as more scientific. He believed that the practice of measuring between the iliac spine and the malleoli was far more prevalent in America than in Europe, where but little confidence was placed in it.

DR. MCBURNEY referred to the case of a man, about forty years of age, who three weeks ago came under his observation after the receipt of an injury of the left hip. The disability was great; but there was neither eversion nor inversion. As the patient lay upon a flat surface, it was evident that there was apparently very great shortening of the limb on the injured side; that is, the sole of the foot on the injured side was drawn markedly above that on the uninjured side. On measuring the two limbs, a curious discrepancy was detected. Measurement on the injured side, from the anterior superior spine of the ilium to the malleolus, showed that there was one inch and one-quarter *lengthening*. The absurdity of this was very apparent; and on a further inquiry and examination, it was found that the patient had had necrosis of the right tibia many years ago, this leading to improper growth of that bone, and on measurement it was found that the entire discrepancy was in the length of the two tibiæ. Dr. McBurney then measured along Bryant's line, and found that the measurements were equal on both sides. The case proved to be one of contusion and not fracture.

DR. L. A. STIMSON said that at one time he measured a large number of cadavers, and afterward laid bare the bony points, and repeated the measurements, and found considerable discrepancies between the results of these two measurements.

THE PRESIDENT. But does not the fact remain that if unreliable within small ranges for diagnostic purposes, yet in actual practice the method of measuring from the anterior superior spine of the ilium to the malleolus is for prognosis sufficiently trustworthy, as it is the common acceptation that if there is three-quarters of an inch or less of final shortening the patient will get along without limping?

DR. SANDS thought that the case reported by the author of the paper was one in point. The patient was examined by two competent surgeons. One determined the existence of one-fourth of an inch of shortening, which afterward he reduced to one-sixth of an inch,

and the other found from one-half to three-quarters of an inch shortening. Now, if this had been a case in which the *result* of treatment was the point to be decided, two surgeons, equally competent, and employing the same method of examination, would have failed to reach the same conclusion.

THE PRESIDENT said all would agree that it was sometimes very difficult to determine exactly the situation of the bony points, still he did not know of any readier way in making out the actual length of the limb.

DR. HALSTED thought the better way was to use Bryant's test.

OBSTETRICAL SOCIETY OF PHILADEDPHIA.

Stated Meeting, November 6, 1884.

THE PRESIDENT, R. A. CLEEMANN, M.D., IN THE CHAIR.

DR. B. F. BAER presented the specimens and read the following report of a case of

PLACENTAL POLYPUS, WHICH SIMULATED MALIGNANT DISEASE OF THE UTERUS.

The patient was 35 years of age, married, and had two children at full term, the last twelve years ago. She has had several abortions since, but otherwise she has enjoyed good health. Her mother died at the age of thirty-eight, of cancer of the uterus. In the early months of this year, our patient first noticed that her catameniæ were becoming too frequent, and were attended with expulsive pains and a fetid watery discharge in the intervals. The blood loss increased in quantity, and she soon began to show sings of failing health in pallor and loss of flesh. She would not permit a physical exploration until the latter part of July, when she had a violent flooding, with great pain. *Examination* now revealed to Dr. R. Armstrong, of Lock Haven, Pa., whose patient she was, a healthy condition of the cervix and a normal os, but the body of the uterus was enlarged to more than double its natural dimensions; it seemed to be symmetrical and rather softer than usual. The hemorrhage was controlled by ergot and rest. Although the grumous, fetid discharge and the uterine tenesmus continued, she did not have another severe attack of metrorrhagia, probably because of her exsanguine condition and the fact that she was suffering from septic absorption. Her temperature rising as high as 104° in the afternoon, she had distinct rigors. Her abdomen was tympanitic, and very tender to the touch. The physical condition of the uterus led the doctor to introduce two tents into the cervical canal on September 23d. They were allowed to remain twenty-four hours, although their presence increased the violence of the symptoms. When the tents were removed, a rather soft, friable mass could be felt presenting at the internal os. This led to a fear that the disease might prove to be malignant. A severe colliquative diarrhœa now set in, and the patient's strength became so much reduced that nothing could be done except to administer remedies to check the diarrhœa and prevent collapse.

On the morning of the 25th, through the kindness of Dr. Armstrong, I saw the patient; temperature 103°, pulse rapid and weak, stomach irritable, rejecting everything taken, bowels still quite relaxed. Her face presented the ashy hue of malignant disease. The outlook was not favorable for an operation, which would necessitate the dilatation of the cervix sufficiently to remove the diseased tissue which evidently occupied the uterine cavity, but it was the only course to pursue. Ether was administered. The uterus was found retroverted, and adherent to the floor of Douglas's cul-de-sac. The cervix was rigid, and but slightly patulous. In view of the existing peritonitis, we concluded that it was best that I should endeavor to remove the contents of the uterus without a further attempt at dilatation, fearing rupture of adhesions and increased inflammatory action. I passed the wire loop of the écraseur through the os, and by careful manipulation luckily succeeded in guiding it over the tumor and up to its attachment. Drawing upon the wire, it closed around the pedicle and severed it. The tumor was seized with a volsella forceps and delivered. The index finger could now be passed into the cavity of the uterus. The pedicle was situated on the posterior wall near the fundus. The tissues at that point were soft and friable, but the remainder of the surface of the uterine cavity appeared to be free from disease. The stump was cauterized with nitric acid, and a two-grain opium suppository placed in the rectum. Convalescence was rapid and satisfactory.

On section and close examination the specimen very much resembles placental tissue, and the microscope shows typical placental villi in its structure. It is the placental polypus described by C. Braun in 1851, and somewhat resembles the fibrinous polypus of Kiwisch, who taught that these polypi might arise from long persistent hemorrhage, a kind of apoplexy of the womb, a large coagulum forming, the upper part consisting mostly of fibrin and adhering by a stalk to the uterine wall, whilst the lower consists of red, soft coagulum having a coat of firm fibrin. Scanzoni does not admit this view. He contends that these are cases of abortion, and would, therefore, fall under the class of placental polypi (Barnes). My own experience agrees with that of Scanzoni. These polypi cause profuse metrorrhagia, and sometimes, as in this case, blood poisoning.

This case furnishes another strong argument in favor of the entire removal of the decidua or placenta after abortion. Who can tell how many lives are lost, or in how many cases the health is undermined by a neglect of this procedure? Death would inevitably have occurred in this case, if the uterus had not been emptied. The patient may suffer for months or years as a result of neglect. In this instance, the fault was in the patient, for she had been properly advised by her physician. It is true that many cases escape without serious injury, but that does not prove that the principle and practice of immediate removal is not always the safe one; for here is a case in which a neglected abortion had apparently passed off safely, but it almost destroyed the patient's life a long time afterwards.

Malignant disease was properly suspected from the rapid development of such grave symptoms, from the general cachectic appearance of the patient, and from the sensation conveyed to the finger when touching the growth *in situ*. But when it was found that it had a limited point of attachment, and that the uterine cavity was healthy at all other points, this hypothesis was

weakened; and when more careful examination of the specimen, and investigation with the microscope showed it to contain placental villi, its benign character was assured.

DR. MONTGOMERY remarked that in cases in which partial dilatation of the uterine canal had been accomplished before the patient presented, the best instrument to continue the dilatation is the mechanical urethral dilator of Dr. A. H. Smith.

HAIRPIN IN THE UTERUS.

DR. B. F. BAER exhibited a hairpin, removed from the uterine cavity of a patient, sent to him by Dr. Pancoast, of Camden, N. J. The woman, believing herself to be pregnant, had tried to produce an abortion by inserting the pin by grasping the points, and inserting the blunt end. The patient had obtained a view of the parts in a mirror placed upon the floor. The presence of the pin was readily detected by the uterine sound. He at first thought of dilating with tents, but the patient being greatly alarmed and very importunate, he used the steel dilator. One point of the pin became embedded, in its descent, in the tissues of the cervix, and required dissection to release it.

DR. WHARTON SINKLER exhibited a hairpin removed from the vagina of a patient who had tried to introduce it into the uterus to produce abortion. She had failed in her purpose, and had also failed to remove it from the vagina. The doctor found the points of the pin widely separated, presenting downwards, and hooked into the walls of the vagina. By bringing the points close together, the pin was removed without difficulty. It had been in the vagina for some time.

NEW YORK COUNTY MEDICAL ASSOCIATION.

Stated Meeting, November 17, 1884.

THE PRESIDENT, WILLIAM DETMOLD, M.D., IN THE CHAIR.

DR. CHARLES A. LEALE read a paper, entitled

A STUDY OF ASIATIC CHOLERA DURING THE EPIDEMIC OF 1866.

The subject, he said, was of interest, in view of the fact that America was again threatened with cholera. Having mentioned that there was at present a considerable outbreak of the disease in India, he referred to the recent epidemics in France, Spain, and Italy, and to the present visitation of the city of Paris of the scourge. It had not as yet appeared either in Great Britain or the United States, but it seemed improbable that we should escape. Still the experience of the past showed that this country might be kept free from it if the greatest possible precautions were taken to guard against its attack. If it should be introduced, it would be through the agency of commerce, and practically the only danger was from infected rags and the clothing of passengers.

In 1865 the United States were threatened with a visit from cholera, but it was not till the summer of 1866 that the outbreak of the disease occurred here. In 1866 there were 1158 deaths from it in New York City; but so vigorous were the measures adopted for its suppression that in the year 1867 there were but 27 deaths. During this latter year, however, cholera spread outward over the country to the extent of a thousand miles or more. The history of this epidemic showed that it was extremely difficult to arouse the public to an adequate sense of the danger of such an outbreak of cholera until it actually occurred, so that in the year 1865, when much might have been accomplished in the way of prevention, the health officials were not permitted to make the preparations and enforce the precautions which they deemed advisable. Another fact proved by it was that when such an epidemic had once broken out it was very difficult to keep the people from overdoing the matter of prevention, as regards taking unnecessary and injurious quantities of medicine, etc.

In February, 1866, Dr. Leale came to New York broken down in health from his arduous service in the army during the war, and, attending some of the lectures at the colleges, was much impressed by the teachings of Professors Alonzo Clark and Austin Flint in regard to the prevention and treatment of cholera, the correctness of which he not long afterwards had the opportunity of practically testing. In carrying them out he had the satisfaction of saving many useful lives. At this time Dr. Flint distinctly prophesied that cholera would be in New York before the end of the summer. Not long after this. Dr. Leale made a voyage to England, as a ship surgeon, for the benefit of his health, and, on the 2d of May, commenced the return trip from Liverpool as surgeon to the fine packet "Harvest Queen," a vessel of 1500 tons, with 836 passengers. At this time there were waiting in Liverpool for embarkation no less than 5000 emigrants, and cholera had already commenced to threaten them. Before sailing, therefore, he made a very rigid examination of all the passengers of the "Harvest Queen," with the result of excluding two of their number, one of whom—a young woman of twenty—had already been attacked with cholera. By the adoption of this precaution, and the enforcement of strict sanitary rules, he was enabled to reach America without having a single case of cholera on board, although the cabins were, in many respects, a typical hotbed for the development of the disease. The voyage, which lasted until June 4th, was very stormy, rendering it necessary to keep the hatches closed, and, as 600 of the passengers were seasick, there was plenty of filth and bad air, to say nothing of the overcrowding and the fear which the rough weather excited. Still, notwithstanding these favorable conditions for cholera, there remained something wanting, and that was the specific causative agent of the disease. On the day after this vessel sailed, another ship—the "Helvetia"—started, with 900 passengers on board. Cholera now developed, and she was obliged to put back; but, before the outbreak ceased, the surgeon and forty others fell victims to it. On the 29th of May she sailed again, and this time, on account of the efficiency of the sanitary measures resorted to, there was not a single case of cholera on board during the voyage.

Strict quarantine Dr. Leale regarded as essential; but in case of that failing to prevent cholera from reaching a city, it was the duty of physicians to report all cases immediately, and to coöperate with the Board of Health in preventing the spread of the infection. In this connection he referred to the admirable suggestion, afterwards carried out, which the President, Dr. Detmold.

made to the Board of Health in 1866, in regard to the purchase of the clothing and bedding of all cholera patients among the poor. Such effects could, therefore, be burned up with certainty, while previously it was too commonly the practice to hide such infected articles, and thus frequently assist in spreading the contagion. In the practical study of cholera, Great Britain had done more than any other nation, on account of the peculiar facilities for such investigations which the English physicians had; and the names of such men as Macnamara, Farr, Gull, Wilson, and others, would always be held in remembrance for the knowledge which they had contributed on the subject. Among the points which seemed to be established in regard to the disease were the following:

(1) The special causative agent of cholera was capable of adhering to various objects, and was portable.

(2) When not brought into immediate contact with portable substances with some power of absorption, it became lost.

(3) The period of incubation in cholera was exceedingly short.

(4) The application of artificial heat was of essential service in the treatment.

The first case which Dr. Leale saw in New York was that of Peter Crow, of 440 W. Fifty-second Street, a car-driver on the Tenth Avenue Railroad, who contracted the disease from sitting on some bundles of emigrants' clothing in the front of his car. This was at noon on August 12, 1866, and seven and a half hours afterward symptoms of cholera showed themselves. When seen by Dr. Leale, he was in the stage of collapse; but with great care and watchfulness, he was saved. Although the endeavor was made to keep the man's children away from the house, Dr. Leale's injunctions were disregarded, and during the next few days two children, aged respectively three and six years, were taken with the disease in its most violent form and died; the one seven hours after the appearance of the first premonitory symptom, and the other ten hours. The wife was taken August 19, but was convalescent on the 21st. She was much depressed, however, by the death of her children, and symptoms of typhus fever setting in, she died on the 24th. There were in all nineteen cases in this Fifty-second Street outbreak, and it was a fact that every case was contracted by direct personal contact with the infected clothing or bedding of cholera patients. Not one of the numerous individuals who were from time to time in the rooms of the cholera patients, but who did not come in contact with the *contagious virus*, suffered from the disease. An analysis of these nineteen cases showed that Peter Crow was in good health up to the time that he sat upon the emigrants' clothing on the street car; that not a case occurred in which there was no contact with the excretions of cholera patients; and that, if properly treated, the disease was of short duration. None of those treated early died, except Mrs. Crow, whose death was attributed to typhus fever following cholera; and the two children, in whose cases the onset of the disease seemed of peculiar violence and malignancy.

For one year Dr. Leale was visiting physician for the district lying between Forty-fifth and Eighty-fifth Streets and Fifth Avenue and the Hudson River, and in no instance was there any reappearance of cholera where it had once occurred. Animals were entirely unaffected by the disease, and he had a good opportunity for observation in this particular among the numerous shanties with which the district abounded. Dogs, chickens, goats, and cats were seen to swallow water or food contaminated with the excretions of cholera patients; but although they were kept under observation for a considerable time afterward, this did not seem to have the slightest ill-effect upon the health of the animals.

It seemed probable, therefore, that the specific cause of cholera found a suitable lodging-place only in the alimentary canal of the human subject. That the disease was due to a specific cause he could not doubt. While during the late war there were over a million cases each of intestinal and malarial disease, there was not a single one of Asiatic cholera.

He agreed with Dr. Lewis A. Sayre, when he said before the American Medical Association in 1866, that the Government would be responsible if cholera should obtain a foothold in America. A strict quarantine should be maintained; but a long detention at quarantine was wholly unnecessary, since experience had taught that an infected vessel and the clothing of her passengers and crew could be rendered perfectly innocuous within a few minutes by proper fumigation and disinfection. In the same manner Prof. R. O. Doremus purified the infected wards of Bellevue Hospital, so that on the very next day after the fumigation the late Dr. James R. Wood placed in them patients who had just undergone capital operations with entire confidence, as the result proved, that no septicæmic trouble would ensue.

In all the cases of cholera which came under his care, except those in Fifty-second Street, Dr. Leale had no difficulty in preventing the spread of the disease by fumigations of sulphur and other sanitary precautions; but in this locality new cases from time to time occurred, and so, at last, he appealed for help to Col. Edward Barry Dalton, M.D., at that time the efficient head of the health department. Col. Dalton promptly responded to this appeal, and personally coming into the district with a large sanitary corps, he removed all suspected articles and caused enormous quantities of chlorine to be generated in all the houses in which cases of cholera had occurred. The result was that not a single case occurred after this; and sanitary chemistry thus achieved a striking triumph.

In regard to the effect of cholera upon pregnant women, Dr. Leale had had the opportunity of making a number of observations, among which were the following: During an epidemic the fear of the disease might kill the fœtus or produce an abortion. If a pregnant woman took cholera, and recovered, the disease was likely to kill the fœtus, which might perhaps remain in utero until term.

Again, other pregnant women at the time of an epidemic of cholera, notwithstanding the most fearful agitation, would carry living children until the end of the full nine months.

Having mentioned that in case of a visitation of this country with cholera New York City would be a more satisfactory place of residence than many smaller cities, towns, and villages in the country, on account of the vigilance and efficiency of its sanitary service, he gave his conclusions. Among them were the following:

When Asiatic cholera appeared in America it was apt during the two or three years following its appearance to extend over the country. The disease seemed to be due to a peculiar ferment, the exact nature of which had not as yet been positively determined. It had been demonstrated that a decidedly acid condition of the alimentary canal interfered with the harmful action of this ferment. The disease was self-limited and of short duration. It was amenable to treatment and good nursing. In the treatment the recumbent posture, the application of artificial heat, and the giving of crushed ice or small quantities of water, to supply the waste of fluid in the system, are useful as adjuvants.

In giving nourishment, care was to be taken to avoid overloading the stomach, lest acute indigestion might be brought on. In the way of medicinal treatment, the following formula had proved of great service in his hands:

℞.—Morphiæ sulph. . . . . gr. j.
Tinct. cardamom. comp. . . . ℥j.
Tinct. capsici, ... ℥iij.
Spts. camphoræ, ... ℥j.—M.

Of this, a teaspoonful in two ounces of water was to be given every fifteen minutes, until the symptoms were rendered tolerable. It was then to be given at longer intervals until the effect of the morphia was seen in the diminished pupil, when it was to be temporarily suspended. This prescription might be required for at least three days. In some instances it was better to give the medicine in solid form. For the painful cramps so frequent in the limbs in cholera, circular pressure with the hand or with a bandage was very useful; the pressure to be removed as soon as the cramp was over. All the linen of the patient was to be subjected to dry heat or to a washing in a watery solution of alum (1 part to 50); alum being an excellent germicide, and doing no harm to the texture.

On motion of Dr. A. Flint, the discussion of the paper was postponed.

PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting, November 3, 1884.

THE PRESIDENT, DR. D. HAYES AGNEW, IN THE CHAIR.

TRACHEOTOMY WITHOUT A TUBE.

DR. J. B. ROBERTS said that he had always used a canula in performing tracheotomy, but he had become so dissatisfied with the tube and the difficulty in keeping it free that he decided that the next time he did the operation he should omit the tube. He had had such a case that day in a child three years old strangling with not very marked symptoms of blood-poisoning from diphtheria. The attending physician considered it a case of croup. He opened the trachea in the upper part, cut out a rectangular piece, and on one side stitched the skin to the trachea, and attempted to do the same on the opposite side, but the suture pulled out and he decided not to reinsert it. He left the patient perfectly comfortable. He desisted from the attempt to put in more stitches, because he thought that the up and down movement of the trachea would take place better, the fewer the sutures. By pulling on the suture which is in place, the wound, which appears as a slit, can be expanded to three times its usual extent. This seemed to him better than the double canula, which is liable to become choked with secretion. He asked whether any of the members had had such cases, and whether ultimately there had been stricture or other difficulty.

DR. PACKARD thought the great objection to cutting out a piece of the trachea was the danger of constriction of the canal. In one of his cases of tracheotomy, which did perfectly well, the child was brought to him several years afterwards, and the state ment made that it had occasionally a little stridor of the voice. This seemed to be due to the presence of a little fold of mucous membrane, perhaps at the upper part of the incision. Whenever the child took cold this became congested and swollen, and interfered with the passage of air. There was no tendency to suffocation. There was simply a hoarseness, which seemed to occur below the larynx.

In regard to the tube, he had no doubt that he lost one case, on the tenth day, from the rasping of the tube against the posterior wall of the trachea. The child had been breathing for an hour without the tube, but the physician, who had given the case unremitting attention, did not like to leave without inserting the tube, and he put it in. In a few hours symptoms of irritation of the trachea appeared, and the child ultimately died. There was some hemorrhage, and it was found that the trachea had been eroded by the tube.

He had only done tracheotomy without a tube in one case. That was in a boy, nine years of age, who was evidently suffering from diphtheria, and his only chance seemed to be from tracheotomy. He had no difficulty in attaching both sides of the incision in the skin to the trachea. The child died, however, within twenty-four hours after the operation.

One of the great advantages of the tube is that it enables the secretion to be entirely cleared away, so far as it collects below the tube, without its passing into the upper air-passages, and without its being swallowed. He thought it important to prevent the passage of diphtheritic exudation, if any such there be, into the air-passages, with possible infection of the system. He should be loath to cut out a portion of the trachea large enough to make any material difference in the passage of air. By making a simple slit long enough a sufficient opening is obtained.

If the tracheotomy-tubes could be made oval, with the long diameter corresponding with the slit in the trachea, it would be an advantage. A much larger tube could then be inserted without pressing on the walls of the trachea. It would also be an advantage to have the lower portion of the tube bevelled off posteriorly, so that it should not press against the trachea and produce erosion. The testimony in favor of tracheotomy without a tube, he thought was very strong.

DR. J. H. BRINTON recalled two cases, one in his own practice and one in that of another surgeon, in which the operation suggested by Dr. Roberts was performed. In both cases a parallelogram was removed from the trachea. These were cases of diphtheria. The membranes were readily ejected, and there was far less trouble than from the tube. Both cases, however, died from the impression of the diphtheritic poison on the system. In a similar case he should try to avoid the

annoyance of the tube. In the cases referred to there was no difficulty in inserting the sutures.

DR. NANCREDE had seen Dr. Lenox Hodge perform a good many tracheotomies, and he did it very well, but on one occasion he had to give it up. When he got to a certain point, although the child had not been much cyanosed before the operation, the breathing became so much interfered with that he had to put in a tube. In this case the neck was not fat, and the trachea was prominent. He himself had performed one or two tracheotomies in children where the neck was so swollen that it would have been impossible to attach the skin to the trachea, and in which the tissues would have sunk in and closed the opening. He has frequently noticed in children, after diphtheria, that when the tube is taken out there is marked dyspnœa immediately. If the tube is left in for several days, ulceration might take place. It is the practice of some to remove the tube in twenty-four hours, examine it, and replace it, or use a tube of a different length or diameter.

DR. PACKARD said that a number of years ago he performed tracheotomy on a girl of twenty-one for laryngeal stenosis. Her life was prolonged seven years by the operation. In this case the tubes could not be removed for five minutes without causing great distress and alarm on the part of the patient and inducing a condition of cyanosis. The best plan in such cases would be to have two tubes, and when one was slipped out at once to introduce the clean tube.

There is an important point about the cleansing of the tube in children to which he referred. We generally consider that when we clean the inner tube that the air-passage is perfectly clear, but it sometimes happens that, notwithstanding the removal of the inner tube, there is still difficulty in the respiration. A feather may be passed into the trachea, removing a little mucus, but still the breathing is interferred with. He thinks that this is due to the gummy secretion on the outer tube and to the attachment of still other secretion at the lower portion, which is sucked up with expiration and constitutes a certain amount of obstruction to inspiration afterwards.

DR. ROBERTS had seen the same trouble. He had attributed it to a little plug of membrane acting as a valve. He had seen the trouble disappear in one case by removing the tube and having a large amount of material expelled by coughing. He had seen one case which died suddenly from closure of the tube, although an intelligent medical student was present at the time. This is one reason why he is anxious to get rid of the tube if that is possible.

DR. NANCREDE had had the same difficulty in keeping the tubes clean. In one case in which he performed tracheotomy for stenosis, he found hot soda water answer as well as anything. When he performs tracheotomy in children he always leaves a tracheal dilator with the friends, not that he thinks that they will be able to get it into the trachea, but if it is necessary to remove the tube they can stretch the tissues and in this way open the incision in the trachea. He saw a tracheotomy performed a short time ago in which the external incision and the opening into the trachea were free, but there was some irregularity in the two incisions, and he believed that the child would have died if the tracheal dilator had not been at hand. Although this did not enter the trachea, it separated the external tissues, permitting the entrance of air into the trachea.

When there is any question as to the plugging of the tube he takes it out and uses the long tracheal forceps. Last Christmas he saw a case on which he had operated two days before. When he got to the house the boy was blue. The tubes were clear; he passed the tracheal forceps through the tubes, but got nothing. He then removed the tubes and passed the forceps and removed a plug of membrane from the right bronchus, and also one from the left bronchus. The boy at once resumed his natural color, and for twelve or fifteen hours was perfectly comfortable.

He believed that the credit for a successful result after tracheotomy in croup belongs more to those who attend the case than to the operator. He always leaves directions that if there is difficulty in the breathing, the tubes are to be removed and the tracheal dilator introduced and kept in place while they send for him. Dr. Hodge's first successful case was saved in that way.

DR. J. EWING MEARS said that some years ago he had to perform tracheotomy suddenly in the course of an operation for excision of the tongue. He had no tracheal tubes at hand, but kept the opening patulous by means of a hairpin bent in the shape of an eye speculum. The following day the patient was breathing so comfortably with the improvised arrangement that he did not insert a tube.

The objection made against the posterior portion of the tube could be overcome by keeping the tube out altogether, and keeping the opening patulous with some other form of apparatus which would simply pass into the opening. Such an instrument would, he thought, possess a great advantage over the tube.

DR. PACKARD said that the idea which Dr. Mears spoke of is an excellent one and had been in his mind for some time. Mr. Kolbe devised an instrument for him somewhat on this principle. It consists of a steel plate, projecting from the posterior surface on which are two wire loops, the upper one being short and intended to keep the upper portion of the incision patulous, while the lower loop is longer and curved downwards and passes into the trachea, keeping the instrument in position. This longer frame is necessary. If it is not used, the swelling which occurs after the operation (he did not refer to the inflammation and induration, which is one of the most unfavorable signs in croup), but when the swelling in the neighborhood of the wound occurs the frame will be pulled out of the trachea and the wound in the trachea will be closed while that in the skin will be kept open.

DR. LEVIS had tried a number of expedients. One, that he liked very well, was to pass a wire stitch through the trachea, pass it through the integument, and afterwards stretch the integument. He had also used sheet lead, but this is liable to slip out. He has on some occasions cut out a piece of the trachea, but he does not like this very well on account of the stenosis which may follow. He has employed flexible tubes, and has sometimes fastened the tube to the skin by means of wire sutures, leaving the wire so that it could be untwisted. This is more pleasant to the patient than the use of tapes around the neck, which sometimes have to be drawn very tight. There is a disadvantage connected with the tube, and that is that the lower end of it

may impinge on the trachea, causing ulceration and death.

DR. S. W. GROSS said that Dr. Roberts's point had not yet been answered. He wanted to find out whether stenosis results from excision of a portion of the trachea. This tube is made more or less rigid by its cartilaginous rings, and he should like some one to explain how stenosis can occur.

DR. LEVIS said that by the ordinary process of cicatricial contraction.

DR. S. W. GROSS did not believe that the excision of a portion of the trachea in these cases is ever followed by contraction. He knows of no reason why new cartilage should not be formed. He would suggest that this matter be made a subject of experimental study by Dr. Roberts.

DR. W. H. PANCOAST said, in regard to his father's experience in later years, that after making the incision he removed a little piece of the trachea. He also used a lead wire to hold the soft tissues apart.

DR. ROBERTS was inclined to think with Dr. Gross that the term stenosis, as applied to the trachea, is a fallacy. Such a limited excision of the cartilaginous and fibrous tissues should not produce stenosis. The cases of supposed stenosis may have been cases in which there was interference with rhythmical up-and-down movements of the trachea.

DR. MEARS said that if any portion of the tracheal wall was cut out, he thought that the tissue formed in repair would produce a band extending straight across. This would certainly reduce the calibre of the tube.

DR. W. W. KEEN called attention to the fact that no one makes an opening large enough for the free movement of the tube. If no tissue is removed, and the tube is left in for any length of time, necrosis of the cartilage occurs, and nature does what the surgeon does in the other case. If there should be any truth in this point about stenosis as the result of contraction, it seemed to him that it should occur in every case in which the tube has been left for any length of time.

CORRESPONDENCE.

VAGINISMUS.

THROUGH the courtesy of the Editor of *The Canada Medical and Surgical Journal*, we are in receipt of the following note:

DEAR SIR: The reading of an admirably written and instructive editorial in the Philadelphia MEDICAL NEWS for 24th November, on forms of vaginismus, has reminded me of a case in point which bears out, in an extraordinary way, the statements therein contained. When in practice at Pentonville, Eng., I was sent for, about 11 P. M., by a gentleman whom, on my arriving at his house, I found in a state of great perturbation, and the story he told me was briefly as follows:

At bedtime, when going to the back kitchen to see if the house was shut up, a noise in the coachman's room attracted his attention, and, going in, he discovered to his horror that the man was in bed with one of the maids. She screamed, he struggled, and they rolled out of bed together and made frantic efforts to get apart, but without success. He was a big, burly man, over six feet, and she was a small woman, weighing not more than ninety pounds. She was moaning and screaming, and seemed in great agony, so that, after several fruitless attempts to get them apart, he sent for me. When I arrived I found the man standing up and supporting the woman in his arms, and it was quite evident that his penis was tightly locked in her vagina, and any attempt to dislodge it was accompanied by much pain on the part of both. It was, indeed, a case "De cohesione in coitu." I applied water, and then ice, but ineffectually, and at last sent for chloroform, a few whiffs of which sent the woman to sleep, relaxed the spasm, and relieved the captive penis, which was swollen, livid, and in a state of semi-erection, which did not go down for several hours, and for days the organ was extremely sore. The woman recovered rapidly, and seemed none the worse.

I am sorry that I did not examine if the sphincter ani was contracted, but I did not think of it. In this case there must have been also spasm of the muscle at the orifice, as well as higher up, for the penis seemed nipped low down, and this contraction, I think, kept the blood retained and the organ erect. As an instance of Jago's "beast with two backs" the picture was perfect. I have often wondered how it was, considering with what agility the man can, under certain circumstances, jump up, that Phineas, the son of Eleazar, was able to thrust his javelin through the man and the Midianitish woman (*vide* Exodus); but the occurrence of such cases as the above may offer a possible explanation.

Yours truly,

EGERTON Y. DAVIS,
Ex. U. S. Army.

CAUGHNAWAGA, QUEBEC, 4th December, 1884.

NEWS ITEMS.

VIENNA.

(*From our Special Correspondent.*)

THE BACILLUS OF SYPHILIS.—Dr. Lustgarten, a young Viennese physician, who spent some months in Prof. Weigert's laboratory in Leipzig, and to whom a place as assistant in Prof. Kaposi's Clinic for skin diseases in the Vienna Hospital is reserved, will communicate to the Vienna Society of Physicians, at its next meeting, the results of his investigations in Leipzig. As those results will certainly attract much attention and interest wherever they become known, it is a happy accident that private communication makes it possible to lay in advance before the readers of THE MEDICAL NEWS a short abstract of Dr. Lustgarten's discovery.

It must be said, however, that Dr. Lustgarten is not to be considered as one of Prof. Weigert's pupils, but that he is only indebted to him for the facilities of his laboratory.

Dr. Lustgarten has found a new bacillus which he considers as characteristic of syphilis, since this bacillus has been found nowhere else but in syphilitic tissues, namely, in a gumma and in several cases of scleroma syphiliticum. The tumors showed, on thin sections, when treated in a specific way with certain coloring matters, bacilli, which, though in shape and size resembling tubercle-bacilli, could easily be diagnosticated as quite different from them by the reaction toward various staining fluids. Dr. Koch recognized the dif-

ference between both kinds of bacilli and the morphological individuality of the bacillus found by Lustgarten. There is one more distinguishing characteristic of the bacillus of syphilis, and that is that it never is found outside of cells, but always in their body.

The results of further experiments on the cultivation of the new bacillus, and on infection of animals by subsequent cultures of it, and further microscopical investigation, are to be expected before the last word on the new bacillus can be said.

NEW YORK.

(From our Special Correspondent.)

THE SAMPLE DISTRIBUTION plan of certain pushing pharmacists has reached great and disagreeable proportions here. Our desks are loaded with bottles of cod-liver oil and malt in every possible combination and degree of nauseating stickiness, while beef peptonoids and purgative pills tell of the enterprise of these benefactors of humanity. There is a phrase among theatrical people who take a new play in the provinces before producing it in large cities—"trying it on the dog." How suggestive this is of the pharmaceutical possibilities that are given to us!

This nuisance is a great one, for it leads to the discontinuance, to some degree, in legitimate prescribing, and the medical man unconsciously advertises the wares which the patient subsequently buys for himself.

NOVEL WRITING seems to be the rage among medical men, and the veteran Dr. Holmes, who set the example, is probably responsible for this order of things. Within the past year Dr. Weir Mitchell and Dr. W. A. Hammond have placed their productions before the public. If we are to believe the newspapers (which are generally well informed), Dr. Hammond has at least four new novels "on the stocks," some of which are to invade the field worked by Hugh Conway and Wilkie Collins. What a chance there is for other specialists! Now the gynecologist may weave a romance about the lost pessary, and call the heroine "Curetti;" or the surgical novelist may kill off his hero with strangulated hernia or epithelioma. It is reported that Dr. Hammond's successful novel, "Lal," is to be dramatized, and produced shortly.

PITTSBURG.

(From our Special Correspondent.)

PITTSBURG OBSTETRICAL SOCIETY.—On Tuesday evening, November 25th, a number of the physicians of Pittsburg and Allegheny organized the Pittsburg Obstetrical Society. Dr. G. B. Fundenberg was elected President; Drs. D. N. Rankin and John P. Sterritt Vice-Presidents; Dr. George MacCord Secretary, and Dr. Stevenson Treasurer. The constitution of the Philadelphia Obstetrical Society was adopted, with one or two slight changes. The code of ethics of the American Medical Association was adopted to govern the Society. The Society held its first regular meeting on Tuesday evening, December 3d. The exercises of the evening consisted in a lecture on lacerations of the cervix uteri by Dr. Sutton. The lecture was illustrated by beautiful drawings, and was followed by a fair discussion. It is the intention of the Society, when its membership has reached fifty, to have the proceedings reported by a stenographer and to some extent journalized. There are at present about thirty members; the number of members will not be limited.

THE CHOLERA IN FRANCE.—The Department of State has received official information through the French Ambassador at Washington that, excepting Toulon, cholera has entirely disappeared from France.

CHOLERA ITEMS.—Official Consular sanitary reports from Rome state that there were 2774 cases of cholera and 1418 deaths in Italy during the week ending September 30th, and 773 new cases, with 451 deaths, for the week ending October 21st. The U. S. Consul adds: "The epidemic appears to be slowly reaching its end, and no official reports are being made for these provinces since the 21st of October." There were 12 deaths from cholera in Calcutta during the week ending October 18, 1884.

Previous to the official announcement, on the 6th of November, of the outbreak of cholera in France and Algiers, the following number of deaths are now officially acknowledged to have previously occurred from this disease: October 18th to the 25th—Marseilles 7, Niemes 4, Nantes 4, Perpignan 2, Le Havre 3, Algiers 45; total, 65. October 25th to 31st—Marseilles 2, Niemes 1, Nantes 25, Perpignan 1, Le Havre 3, Algiers 22; total, 54.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM DECEMBER 2 TO DECEMBER 8, 1884.

IRWIN, B. J. D., *Major and Surgeon.*—Granted one month's leave of absence.—*S. O. 112, Department of Arizona,* November 28, 1884.

O'REILLY, ROBERT M., *Captain and Assistant Surgeon.*—Assigned to duty as Attending Surgeon Washington City, D. C., to date from October 20, 1884.—*S. O. 284, A. G. O.,* December 4, 1884.

KNEEDLER, WILLIAM L., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at Fort Abraham Lincoln, Dakota Territory, and ordered to Camp Poplar River, Montana Territory. *S. O. 140, Department of Dakota,* November 25, 1884.

PILCHER, JAMES E., *First Lieutenant and Assistant Surgeon.*—To be relieved from duty at Camp Poplar River, Montana Territory, and ordered to Fort Abraham Lincoln, Dakota Territory.—*S. O. 140, Department of Dakota,* November 25, 1884.

MCCAW, W. D., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at Fort Wingate, New Mexico, and ordered to Fort Lyon, Colorado.—*S. O. 228, Department of Missouri,* November 26, 1884.

GRAY, CHARLES C., *Major and Surgeon* (retired).—Died at Geneva, New York, November 26, 1884.

BARROWS, C. C., *First Lieutenant and Assistant Surgeon.*—In addition to other duties, to take charge of Medical Director Office, Department of Arizona, during absence of Surgeon B. J. D. Irwin.—*S. O. 112, Department of Arizona,* November 28, 1884.

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS *should be addressed to No. 1004 Walnut Street, Philadelphia.*